APPLEBY PRIMARY SCHOOL

APPLICATION FOR SCHOOL STAFF TO ADMINISTER MEDICATION TO CHILD

THIS FORM MUST BE COMPLETED BY PARENTS IF THEY WISH THE SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Head Teacher has agreed that school staff who volunteer to do so can administer the medication.

DETAILS OF PUPIL

Full Name: _____ Date of Birth _____

Address: _____ Class _____

_____

_____

Condition or Illness _____

MEDICATION

Name and strength of the Medication (as described on the container)

_____

Form (eg tablets,syrup,cream) _____

How many days will your child need this medication? _____

Date dispensed by pharmacist/doctor _____

FULL DIRECTIONS FOR USE

Dosage & Method to be taken? _____

Time Medication needed? _____

Special Precautions _____

Details of any side effects _____

Can your child self-administer? _____

Procedures to take in an emergency _____

CONTACT DETAILS

Name: _____ Daytime Telephone No _____

Relationship to Pupil _____

Address (if different to above) _____

I understand that I must deliver the medicine personally to the school office and accept that this service is provided by the relevant member of staff and the school/unit on a voluntary basis. I agree to inform the school of any changes to this information by completing a new form at the earliest opportunity.

Date _____ Signature _____

Relationship to pupil _____ Staff Member to Sign _____

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Date	Medication	Amount Given	Amount Left	Time	Issued By	Witness	Comments