

Appendix 4

Parental Medication Administration Request

Please note that we will only administer medication if it has been prescribed by a GP and if the medication needs to be taken 4 or more times in one day.

Name of pupil	
Date of birth	
Year/form	
Name and phone no of GP	
Name/type of medicine <i>(as described on container)</i>	
Expiry date/ end of medication course	
Dosage, method and frequency	
Any known side effects?	
Procedures to take in an emergency	

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	

I give permission for medication to be administered to my child as prescribed.

Date _____ Parent/carer signature _____

Request & prescription label checked by designated staff member & medication accepted.

Date _____ Staff signature _____