REQUEST FOR ADMINISTRATION OF MEDICATION

"Administration & Management of Prescribed Medicines Policy"

Child's Name: .....Date of Birth.....Class: .....

Name of GP: .....Phone No:.....

Medical Condition or Illness.....

Name of medication to be administered.....

Date of expiry of medication.....

Dosage and method .....

Special Instructions.....

Any possible side effects..... .....

I would like a member of staff to administer the above medication on my behalf. I accept that they are acting on my instructions and they cannot be held responsible if the medication is not given or given wrongly. I will inform the school immediately if there is any change in the dosage or frequency of the medication.

Signed.....Parent/Guardian Print Name.....

Received by.....Print Name.....Date.....

Record of administration:

	Date	Time	Dose	Signature		Date	Time	Dose	Signature
1					11				
2					12				
3					13				
4					14				
5					15				
6					16				
7					17				
8					18				
9					19				
10					20				