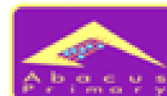
Abacus Primary School



Request for School to Administer Medication

Pupil's Full Name					
D.O.B.		Year group:		Class:	
Medical Condition or illness:					

Medicine

Name/type of medicine (as described on the container)			
Issue date		Expiry date	
Specific dosage and method			
Timing			
For how long will the child be required to take this medication?			
Special precautions/other instructions/storage			
Any known side effects that school needs to know about?			
Self administration - Y / N			
Procedures to take in an emergency			
N.B. Medicines MUST be in the original container as dispensed by the pharmacy.			

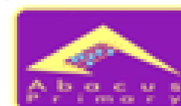
Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I understand that I must deliver the medicine personally to Office Staff on a weekly basis and collect any remaining medication at the end of each term. I accept that the School has a right to refuse to administer medication.

Signed:_______________________________ Date: ______________________



Abacus Primary School

Medication Administration Record

Child's Name:		D.O.B.	
Type of Medicine		Expiry date:	
Dosage		Precautions	

Please enter date, time given, dosage and then staff member to initial.

Date	Mon	Tues	Weds	Thurs	Frid
Time					
Dose					
Staff initials					

Date	Mon	Tues	Weds	Thurs	Frid
Time					
Dose					
Staff initials					

Date	Mon	Tues	Weds	Thurs	Frid
Time					
Dose					
Staff initials					

Date	Mon	Tues	Weds	Thurs	Frid
Time					
Dose					
Staff initials					

Date	Mon	Tues	Weds	Thurs	Frid
Time					
Dose					
Staff initials					