

**ALL SAINTS CE FIRST SCHOOL**

REQUEST FOR A SCHOOL TO ADMINISTER **NON PRESCRIBED** MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Headteacher has agreed that school staff can administer the medicine

**Details of Pupil**

Surname \_\_\_\_\_ Forename(s) \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_\_

M  F

Class \_\_\_\_\_

Condition or illness \_\_\_\_\_

**Medication (Name)** \_\_\_\_\_

**Parents must ensure that in date properly labelled medication is supplied.**

Type of Medication (e.g. Tablet/Medicine/Spray/Drops)

\_\_\_\_\_

Expiry Date \_\_\_\_\_

Any Special Storage Instructions (eg Fridge) \_\_\_\_\_

**Full Directions for use:**

Dosage/Timing/Method of Administration

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Special precautions \_\_\_\_\_

Has this medicine been administered before without any adverse effects?

\_\_\_\_\_

Are there any possible side effects that the School needs to know about?

\_\_\_\_\_  
\_\_\_\_\_

Self-Administration

Yes/No (delete as appropriate)

## Procedures to take in an Emergency

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### Contact Details

Name \_\_\_\_\_

Phone No: (Home/Mobile) \_\_\_\_\_

(Work) \_\_\_\_\_

Relationship to Pupil \_\_\_\_\_

Address

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I understand that I must deliver the medicine personally to The Headteacher or the School Office and accept that this is a service, which the school is not obliged to undertake. I understand that I must notify the school of any changes in writing.

**Signature(s)** \_\_\_\_\_ **Date** \_\_\_\_\_

### Agreement of Headteacher

I agree that \_\_\_\_\_ (name of child) will receive  
\_\_\_\_\_ (quantity and name of medicine)  
every day at \_\_\_\_\_ (time(s)) medicine to be administered eg morning  
break or lunchtime

This child will be given/supervised whilst he/she takes their medication by  
\_\_\_\_\_ (name of staff member)

This arrangement will continue until \_\_\_\_\_  
(either end date of course of medicine or until instructed by parents)

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**(The Headteacher/Authorised Member of staff)**

**The original should be retained on the school file and a copy sent to the parents to confirm the school's agreement to administer medication to the named pupil.**