



Request for School to Administer Medication

We will not be able to give your child medication unless you complete and sign this form.
Thank you.

Name and DOB of child

Class

Condition or illness

Medication & length of time left for
your child to take this medication

Dosage and timings

Any precautions

Procedures to take if there is an
emergency

Contact details (Name and phone
number)

I UNDERSTAND THAT I MUST DELIVER AND COLLECT THE MEDICINE PERSONALLY FROM THE SCHOOL OFFICE

Signed Date

Relationship to Pupil

Staff signature (on receipt of meds)