

GREAT MARSDEN ST. JOHN'S PRIMARY
A CHURCH OF ENGLAND ACADEMY

Administration of Medication Request

DETAILS OF PUPIL

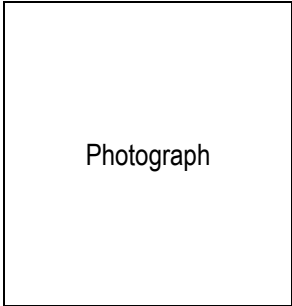
Name _____

Class _____

Date of birth _____

Address _____

Postcode _____



Condition or illness

Date _____

MEDICATION

Name/type of medication (as described on the container) _____

For how long will your child take this medication? _____

FULL DIRECTIONS FOR USE

Dosage and method: _____

Timing: _____

Special precautions: _____

Side effects: _____

Procedures to take in an emergency: _____

CONTACT DETAILS

Name _____

Relationship to pupil _____

Address _____

Daytime telephone _____

Postcode _____

I understand that I must deliver the medicine to the school office in its original container and that it is my responsibility to ensure there is sufficient medication in school for my child's needs at all times. I accept that this is a service which the school is not obliged to undertake.

Signed _____

Date _____

Print name _____

Relationship to pupil _____