

NAME OF SCHOOL \_\_\_\_\_ FORM AM2

REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Principal 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**

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

Name/Type of Medication (as described on the container)

\_\_\_\_\_

Date dispensed \_\_\_\_\_

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

**Full Directions for use:**

Dosage and method

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

NB Dosage can only be changed on a Doctor's instructions

Timing \_\_\_\_\_

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

Are there any 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 \_\_\_\_\_

I understand that I must deliver the medicine personally to \_\_\_\_\_  
(agreed member of staff) 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 Principal

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

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 Principal/authorised member of staff)