STRANMILLIS PRIMARY SCHOOL

Request by parent for school to supervise 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 medication.

|  |  |
| --- | --- |
| **Pupil Details:** |  |
| Surname: |  | Forename: |  |
| Address: |  |
|  |
| Postcode: |  | Male/Female: |  |
| Date of Birth: |  | Class: |  |
| Condition/Illness: |  |
|  |
| **Medication:** |  |
| Name: (as on container) |  |
| Duration: (days) |  | Or until: (date) |  |
| Date dispensed: |  | Expiry date: |  |
|  |
| **Directions for use:** |  |
| Dosage: |  | Time: |  |
| Special precautions: |  |
| Side effects: |  |
| Self-administer: yes/no |  |  |
| Procedures to take in an emergency: |  |
|  |
| **Contact Details:** |  |
| Name: |  |
| Tel. No. |  | Relationship to pupil: |  |
|  |
| Address: |  |
|  |
| I understand that I must deliver the medicine personally to Reception/Miss Cahoon and accept that this is a service which the school is not obliged to undertake: |
| Date: |  | Signature: |  |
|  |
| **Agreement of Principal:** |  |
| I agree that  | will receive medication as above. |
| Pupil will be supervised taking their medication by |  |
| This arrangement will continue until the end date of the course of medication or instructed to do so by parents. |
| Date: |  | Title: | Principal |
| Signature: |  |
|  |