



ST. MICHAEL'S C.E. (AIDED) PRIMARY
Request for School to Administer Medicine during the School Day

Name of child:Class

Medical Condition/illness:
.....
.....

Medicine

Name/Type of Medicine:

Does this medicine need to be kept in a fridge?: Expiry Date:

Dosage

Quantity:

Method:

Timing (this cannot be guaranteed:)

For how many days do you wish the medicine to be administered.....

Special precautions:

Are there any side effects that school should be aware of
.....

Parent/Carer Details

Name:

Daytime telephone number:

Relationship to child:

I understand that I must deliver the medicine to the school office.

I accept that this is a service that school is not obliged to undertake.

I accept that school will dispose of any medicine not collected by parents, once the treatment period has expired.

Signed:Date:

**Refer to the reverse of this form for confirmation of administration of
medicine as detailed above.**

Confirmation of administration of medicine

Medication Dosage

Given by Date

Given by Date

Given by Date

Given by Date

Given by Date

Given by Date