REQUEST TO SELF- ADMINISTER MEDICATION FORM

School will not give your child permission to self-administer unless you complete and sign this form **and** the Headteacher has agreed to self-administration.

Personal Details

Name of pupil:
Contact telephone number:
Condition or illness:

Medication

Name/ type of medication:(as described on the container)
Special storage requirements:
Date dispensed:
Expiry date on medication:
For how long will your child administer this medication?

Full Directions for Use

Dosage:
Frequency/timing:
Method:
Any particular problems with administration?
Side effects:

Parental Declaration

I will ensure that the appropriate staff members are aware when medicine arrives at school.
I will complete another form if any of the above information changes.

Signature:

Date:

Relationship to child: