Argyll and Bute Council **Admin 1a**

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Form for parents to complete if they wish the school to administer medicine.

The school will not give your child medicine unless you complete and sign this form, and volunteer staff have agreed to administer.

Details of Pupil

Surname: _____ Forename(s): _____

Address: _____

Date of birth: _____ Male: ☐ Female: ☐

Class: _____

Condition or illness: _____

MEDICATION 1

Name/ type of medication: _____

Parents must ensure that medication supplied is properly labelled with a Pharmacy or dispensed label which states:

- pupil's name
- name of medicine
- dose
- frequency of administration
- date of dispensing

For how long will your child take this medicine? _____

Full directions for use: _____

NB "AS DIRECTED" is not acceptable.

Dosage and method eg oral ☐ injection ☐ tube feed ☐ other ☐

Timing: _____

Special precautions: _____

Side effects: _____

_____

Self administration: Yes ☐ No ☐

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REQUEST FOR SCHOOL TO ADMINISTER MEDICATION (continued)

Admin 1b

MEDICATION 2

Name/ type of medication: _____

Parents must ensure that medication supplied is properly labelled with a Pharmacy or dispensed label which states:

- pupil's name
- name of medicine
- dose
- frequency of administration
- date of dispensing

For how long will your child take this medicine? _____

Full directions for use: _____

NB "AS DIRECTED" is not acceptable.

Dosage and method eg oral ☐ injection ☐ tube feed ☐ other ☐

Timing: _____

Special precautions: _____

Side effects: _____

_____

Self administration: Yes ☐ No ☐