REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Student Name: ________________________________ **Tutor Group:** __________

Name / Type of Medication: ________________________________

Condition / Illness: ________________________________

Is this medication prescribed by your Doctor? YES/NO (Please delete accordingly)

For how long will student be required to take medication: ________________

Date dispensed: ________________ **Dose:** ________________

Frequency of Dosage: ________________ **Timing:** ________________

Additional instructions/information (eg before/after food, possible side effects, interaction with other medicines, storage instructions):

____

____

I understand that I must deliver the medicine personally, or send it with my child, to Reception, replace any medication used and collect any remaining medication when the course is completed. I accept that the School has a right to refuse to administer medication and that it is my responsibility to ensure that all medication is within the expiry date and to inform the School of any drug changes.

Name: ________________________ Relationship to student: ________________

Signed: ________________________ Date: ________________________

NB: Drugs/Medicines sent to school MUST be in current pharmacy-labelled containers.

School use:

Remaining medication returned/finished course/disposed
(circle accordingly)

Date:

STOCK ROAD · BILLERICAY · ESSEX · CM12 0RT · TELEPHONE: 01277 623171 · FACSIMILE: 01277 632256
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Company Number: 07692668

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DRUG DISPENSING RECORD SHEET

Name of Student: ______________________________ Tutor Group ______________

DRUG	PRESCRIBED YES/NO	DOSE	DATE	TIME	INITIALS

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