REQUEST FOR ADMINISTRATION OF MEDICINE

Name: …… Class: ……..

G.P.: …….. G.P. Phone No.:…….

MEDICINE TO BE GIVEN FOR _____ (ILLNESS)

Dosage and method: ……..
(All liquid medicines must be accompanied by a 5ml medicine spoon or oral syringe)

Date From: …… Date To: ……..

Time to be given: …….....

LUNCH TIME MEDICINE WILL BE GIVEN AT 12:00 (Key Stage One) and 12:15 (Key Stage Two)

Side effects: …….

Any special instructions: ……..…….

I would like a member of staff to administer on my behalf the above medicine. I accept that they are acting on my instructions and they cannot be held responsible if the medicine is not given or given wrongly. I will inform the school immediately if there is any change in the dosage or frequency of the medicine.

Parent/Guardian Signature:……..

Print Name: ……...

Date: ……

Authorised by Principal Signature……Date……