HARLOW FIELDS SCHOOL & COLLEGE

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

DETAILS OF PUPIL			
Surname:			
Forename:			
Address:		M/F:	
		DATE OF BIRTH:	
		CLASS:	
REASON FOR MEDICATION:			

MEDICATION	
Name of Medication:	
For how long will your child take this medication?	
Directions for Use:	
Dosage:	
When to be given:	
How to be given:	
Possible side effects:	

Note: Medicines must be in the original container as dispensed by the pharmacy

I understand to ensure that this medication supplied by me and prescribed by my child's doctor is currently labelled and in date and that I must notify the school of any changes in writing.

I authorise a member of school staff, who is not a trained health practitioner but is trained by the School Nurse to administer medication, or the School Nurse to act on my behalf, to administer the

above medication at the time(s) noted, and using the method(s) described. Please note the School Nurse is not guaranteed to be on the school site when an authorised member of staff administers medication.

Signed ……..…… Parent/Guardian

Date ……

In accordance with Department of Health and Department of Education Guidelines.