THE STAFFORDSHIRE SCHOOLS MULTI ACADEMY TRUST

CONFIRMATION OF MEDICATION DETAILS YOU REQUIRE TO BE ADMINISTERED BY STAFF

Pupil Name:	Date of Birth:	School: RC / SM / TH (delete as applicable)
Address		Telephone Number:
GP Name:	GP Address:	GP Telephone Number:
Details of any allergies or other special instructions (Take in to account any cultural, religious or communication needs)		

Name of Medication	Strength of Dosage	Number/Amount of Medication & time when given	Expiry Date of Medication

If the details above are correct, please sign and return

Name: _____ Signed: _____ Date: _____
(Person with parental responsibility)

Important Note

Please inform the school, immediately should there be any amendment to the following: -

1. Medication or dosage
2. Address or telephone number
3. Doctor or Doctor's telephone number

For School Use:

N.B. All medicines must be stored in the school office (or fridge if required) and be clearly labelled with the child's name.

All medicines should be collected every evening unless required for ongoing conditions e.g. allergies.

Date	Time	Dose administered	Any adverse reaction?	Signature of administering staff member	Signature of witness