HALL MEADOW PRIMARY SCHOOL

REQUEST FOR THE SCHOOL TO ADMINISTER MEDICATION

The school will only administer medication if a suitably trained staff member agrees to do so.

Unless this form is fully completed and signed, we will be unable to administer medication to your child. Please note that it is the parent's responsibility to ensure that all medication is in date and replaced as required. It is the parent's responsibility to ensure that medication has been taken.

PLEASE ENSURE THAT YOUR CHILD'S NAME IS CLEARLY MARKED ON THE MEDICATION.

Child's Full Name:	
Address:	
Gender:	
Medical Condition:	
Date of Birth:	

NAME OF MEDICATION (as described on the packaging)	
How long is your child required to take this medication?	

What dosage is required?	
At what time should it be administered?	
Are there any special precautions or side effects?	
How should the medication be administered? (circle)	**BY THE CHILD** **BY AN ADULT**

I UNDERSTAND THAT I AM RESPONSIBLE FOR DELIVERING THE MEDICATION TO THE SCHOOL AND I ACCEPT THAT THIS IS A SERVICE THAT THE SCHOOL IS NOT OBLIGED TO UNDERTAKE. I ACCEPT THAT IT IS NOT THE SCHOOLS RESPONISBILITY TO ENSURE THAT CHILDREN ARE REMINDED TO TAKE ANY NON-URGENT MEDICINE.

SIGNED: _____ **DATE:** _____ **RELATIONSHIP TO CHILD:** _____

This section to be completed by the school

Person Agreeing to Administer the Above Medication: _____

RECORD OF THE ABOVE MEDICATION ADMINISTERED IN SCHOOL

DATE	TIME	DOSE	ANY REACTION?	SIGNATURE	PRINT NAME