Aberdeenshire
COUNCIL Education and Children's Services

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

This form is for parents to complete if they wish the school to administer medication. The school will not give your child medicine unless you complete and sign this form, and the Head teacher has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Surname: ....

Forename(s): ....

Address: ....

....

....

.... Post Code: ....

Male/Female: .... Date of Birth: .... Class / Form: ....

Condition or Illness: ....

MEDICATION

Name / Type of Medication (as described on the container):..

For how long will your child take this medication? ....

Date dispensed: ....

FULL DIRECTIONS FOR USE

Dosage and method: ....

Timing: ....

Special Precautions: ....

Side Effects: ....

Self-administration: YES / NO

Procedures to take in an Emergency: ....

CONTACT DETAILS FOR

Name: .... Daytime Telephone No: ....

Relationship to Pupil……………………………….Date ....

I understand that I must deliver the medicine personally to (agreed member of staff) and accept that this is a service which the school is not obliged to undertake.

Signature(s): ………………………………………………………………...

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CONFIRMATION OF THE HEAD TEACHER'S AGREEMENT TO ADMINISTER MEDICATION

This form is for schools to complete and send to parent if they agree to administer medication to a named child.

I agree that ***(name of child)*** will receive ***(quantity and name of medicine)*** every day at ***(time medicine to be administered e.g. lunchtime or afternoon break)***.

(Name of child) will be ***given / supervised*** whilst he / she takes their medication by ***(names of members of staff)***.

This arrangement will continue until ***(either end date of course of medicine or until instructed by parents).***

Date: ....

Signed ……………………………………………

(Head teacher or DHT pupil support):