



ADMINISTRATION OF MEDICATION REQUEST
(Short Term)

NOTE: Where possible the need for medicines to be administered at school should be avoided. Parents are therefore requested to try to arrange the timing of doses accordingly.

Staff administer medication on a voluntary basis.

Child's Name:	
Child's Class	
Details of Illness/Condition:	

Please tick the appropriate box

I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of an emergency, as staff consider necessary.

My child will be responsible for the self-administration of medicines as directed below.

I will ensure that the medicine held by the school has not exceeded its expiry date.

<i>Name of Medicine</i>	<i>Dose</i>	<i>Frequency/times</i>	<i>Completion date of course if known</i>	<i>Expiry date of medicine</i>
<i>Special Instructions:</i>				
<i>Allergies:</i>				
<i>Other prescribed medicines child takes at home:</i>				

Signed:	
Date:	

ADMINISTRATION OF MEDICATION RECORD

	<i>Date</i>	<i>Time</i>	<i>Medicine given</i>	<i>Dose</i>	<i>Signature(s)</i>
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
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12					
13					
14					
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16					
17					
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20					