**REQUEST FOR SCHOOL TO ADMINISTER MEDICATION**

Offord Primary School will not give your child medicine unless you complete and sign this form, and the Office Administrator has agreed that school staff can administer the medication.

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| **Child details** |
| Surname | Forename |
| Date of Birth |  |
| Condition or illness |

|  |
| --- |
| **Parent details** |
| Name  | Relationship to child |
| Daytime contact number |  |

|  |
| --- |
| **Medication Details** |
| Name of medication |  |
| Use by date |  |
| For how long will your child take this medication?  |  |
| Date dispensed |  |
| Dosage and method  |  |
| Timing |  |

Parent declaration: I understand that I must deliver the medicine personally to the school office and accept that this is a service which the school is not obliged to undertake.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| For office use only |
| I agree that (child’s name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will receive the above named medication accordance to the above instructions  |
| Signed (Named member of staff): |
| Date:  |