Request for Administration of Medicines

To: Mrs K Stretton
At: Ellistown Community Primary School

From: The Parent/Guardian of:__________________________________**(Full name of Child)**

(Date of Birth)_______________________

My Child has been diagnosed as having:____________________________**(Name of condition)**

He/She is considered fit for school but requires the following **PRESCRIBED** medication to be administered during school hours:

____**(Name of Medication)**

I allow/do not allow my child to carry out self administration **(Delete as appropriate)**
I allow/do not allow my child to carry the medication - **INHALER'S ONLY** - upon themselves **(Delete as appropriate)**

INHALER'S ONLY (Dosage)_________________________at __________
(Times)

PRESCRIBED MEDICATION ONLY
(Dosage)_____________________________
The **PRESCRIBED** medication as indicated above will be administered at **12pm**

With effect from:_____________________**(Date)** to:________________
(Date)

The **PRESCRIBED** medication should be administered by **Mouth/In the Ear/Nasally/Other** (Delete as appropriate)

I undertake to update the school with any changes in routine, use or dosage for routine or emergency medication and to maintain an in date supply of the medication.

I understand that all staff are acting voluntarily in administering medicines to children. I understand that the school staff cannot undertake to monitor the use of self-administered medication (**INHALER'S)** carried by the child and that the school is not responsible for any loss or damage to the medication.

Signed:______________________________**Date:**___________________

Name of Parent/Guardian:_______________________________________**(Please Print)**
Contact Number: __________________________________

*******OFFICE USE ONLY - PLEASE COMPLETE RECORD OF MEDICINE ADMINISTRATION OVERLEAF********

Name of child: ______________________________

Date of birth: ______________________________

Name of medication: ______________________________

Date	Time	Dose given	Name (Print)	Signed

*******OFFICE USE ONLY - PLEASE COMPLETE RECORD OF MEDICINE ADMINISTRATION OVERLEAF********