School Office to Complete	
Medication Expiry Date:	
Expiry Notification Sent:	

REQUEST FOR SCHOOL TO ADMINISTER PRESCRIBED MEDICATION - MED1 FORM

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

PUPIL DETAILS

Name:	
Date of Birth:	
Class:	
Condition / Illness :	

MEDICATION

Medicine Name	Duration of Course	Dosage	Timing	Self-Administer (Y/N)	Date Prescribed

Side effects from the medication that we should be aware of:	
Any emergency procedures we should be aware of:	
Any further information can be completed on the reverse of this form	

CONTACT DETAILS OF PERSON COMPLETING FORM

Name:	
Relationship to pupil:	
Home Tele:	
Work Tele:	
Mobile Tele:	

DECLARATION

- I understand that I must deliver (and where necessary collect) the medicine personally to the office staff.
- I accept that this is a service which the school is not obliged to undertake.
- I confirm that my child's doctor has stated it is necessary for the medication to be taken during the school day.
- I understand that it is my responsibility to ensure that I provide the office with new medication should the one held reach its expiry date.

Signed (Parent / Carer) _____ Date: _____