

ASHCOMBE PRIMARY SCHOOL

Request for School to Administer Controlled Medication

*Form to be completed by parents if they wish the school to administer medication
The school will not give your child medicine unless you complete and sign this form.*



DETAILS OF STUDENT

Name		Male / Female	
Year		Class	
Address		Date of Birth	

Illness / Condition	
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MEDICATION

Medication (as described on the container) Must be received in the original packaging		Expiry Date	
Quantity received		Date Received	
What is the dosage, timings and duration	Dosage:		
	Timings:		
	Duration:		

Any side effects? Special precautions?	
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Procedure to take in an emergency	
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EMERGENCY CONTACT DETAILS

Name		Relationship to Pupil	
Address		Emergency telephone number	

The above information is to the best of my knowledge accurate at the time of writing and I give consent to the school staff to administer the medication in accordance with the school Medication Policy. I understand that I must deliver the medication personally to the school office and accept that this is a service that the school is not obliged to undertake.
I will inform the school office immediately if there is any change to the information on this form, or if the medication is stopped.

Name		Signature	
Relationship to pupil		Date	

ADDITIONAL MEDICATION RECEIVED

Medication (as described on the container) Must be received in the original packaging		Expiry Date	
How many tablets received		Date Received	
What is the dosage?			

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How many tablets received		Date Received	
What is the dosage?			

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]