REQUEST FOR NORTH PRIMARY SCHOOL AND NURSERY TO ADMINISTER MEDICATION

Pupil's full name…….. Class……

Address …….

Condition/ illness…….

Name/type of medication……..

For how long will the child be required to take medication?…….

Date treatment started ……

Total number of times per day that medication is prescribed to be taken (ie 3 times per day / 4 times per day) ……

Please confirm the time that the medication is to be administered in school ……

Additional instructions/information (e.g possible side effects, before/after food)

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Emergency Contacts

Name…… Relationship to child ……

Daytime telephone number ……

OR

Name…… Relationship to child ……

Daytime telephone number……

I understand that I must deliver the medication in a measured dose in a clearly labelled syringe personally to the school office. I must show evidence of the dosage (the original container showing the name and medication) on the first day. The syringe will be given back to the child after medication has been taken.

Name…… Relationship to child ……

Signed …… Date……