

**Medication Administration**

Pupil's Full Name: .....

Date of birth: .....

Address: .....

Contact numbers: .....

Conditions/Illness/Allergies: .....

.....

Medicine Name & Strength	Reason For Medicine	Type/Form	Taken Via	Dose	Time to be given	Is medication required long/short term

Please continue on additional sheet if necessary.

(Details of rectal valium or similar medication should be included as above).

Please give any additional information (e.g. before/after food, interaction with other medicines, possible side effects, storage instructions).

I understand that I must provide the medicine in an original container clearly labelled with:

- Child's full name
- Full name and strength of medicine
- Prescribed dose and time of administration
- Method of administration
- Date of issue
- Expiry date
- Relevant additional labels/information
- Quantity - date dispensed

**We will not administer any medication unless the above requirements are fulfilled.**

Any unused medicine will be returned to you for your own disposal.

I accept that the school has a right to refuse to administer medication.

Signed: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

**It is essential that you tell us of any new or changed prescription and provide the school with permission to administer drugs in school on a new form as necessary**

Medication Administration – continuation sheet

Medicine Name & Strength	Reason For Medicine	Type/ Form	Taken Via	Dose	Time to be given	Is medication required long/short term

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

Relationship to child: \_\_\_\_\_

Print name: \_\_\_\_\_

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