IF WE DO NOT RECEIVE THE CORRECT WRITTEN INFORMATION, MEDICINE WILL NOT BE ADMINISTERED.

PURLEIGH COMMUNITY PRIMARY SCHOOL

Request for School 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 the medication? _____

Date Dispensed: _____

Dosage: _____ Timing: _____

Additional information/instructions (e.g. before/after food, interaction with other medicines, possible side effects, storage instructions) _____

_____

_____

Emergency Contacts:

1. Name: _____ Relationship to child: _____

Daytime Tel No. : _____

Or

2. Name: _____ Relationship to child: _____

Daytime Tel. No. : _____

I understand that I must deliver the medicine personally to the school office and collect any remaining medication when the course is completed. I accept that the school has a right to refuse to administer medication.

Name : _____ **Relationship to child :** _____

Signed _____ **Date** _____

_____

School Use:
Remaining Medication returned to *(name) on* *(date)*

Or disposed of via ..... *on* .....