KING'S LEADERSHIP
ACADEMY WARRINGTON

Request for School to Administer Medication

The school will not give your child medicine unless you complete and sign this form, and that the Principal has agreed that school staff can administer the medication.

Details of Pupil

Name _____

Address_____
_____

M/F _____ Date of birth _____ Class/Form _____

Condition or illness _____

Medication

Name/Type of Medication (as described on the container) _____

For how long will your child take this medication: _____

Date dispensed _____

Full Directions for use:_____

Dosage and method: _____

Timing: _____

Special Precautions: _____

Side Effects: _____

Self-Administration: _____

Procedures to take in an Emergency: _____

Contact Details

Name _____ Daytime Telephone Number _____

Relationship to Pupil _____

I understand that I must deliver the medicine personally, and accept that this is a service which the school is not obliged to undertake.

Date _____ Signature _____ Relationship _____