Wilsden Primary School - Medication in School Request Form

DETAILS OF PUPIL						
Name		M/F	D.O.B.		Class	
Condition or illness *(eg. Asthma, Diabetes, Epilepsy etc.)*						

DOCTOR'S DETAILS					
Name		Medical Practice		Telephone	

MEDICATION AND ADMINISTRATION				
Name of Medication				
Type (tablets, syrup, etc)				
Date Dispensed		Length of treatment		
Dosage instructions				
Method of administration				
Times to be taken		Is precise timing critical?	YES	NO
For medication that needs **not** be administered at pre-set times, please indicate when it should be given *(eg. Before exercise, onset of Asthma attack, onset of migraine etc.)*				

Special storage instructions *(eg, refridgerate)*			
Where will medication be stored overnight?	To remain in school	Taken home daily	
The medication needs to be administered by a member of staff		YES	NO
My child is capable of administering the medication under adult supervision		YES	NO

ADDITIONAL INFORMATION
Precautions or Side Effects :
What to do in an Emergency :

CONTACT DETAILS			
Name		Relationship to pupil	
Contact number			

I understand that I must deliver the medication personally to the school office and I consent to authorised staff administering the above medication to my child. I accept that this is a service which the school is not obliged to undertake.

I consent to medical information concerning my child's health to be shared with either school staff and/or health professionals to the extent necessary to safeguard his/her health and welfare.

I confirm that the medication has been prescribed by a doctor/consultant and that this information has been provided in consultation with my child's doctor/consultant.

Signature		Date	