

Appendix 4

Request for school to administer medication

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

Child's Surname:	<input type="text"/>		
Forename(s):	<input type="text"/>		
DOB:	<input type="text"/>	M <input type="checkbox"/>	F <input type="checkbox"/>
NHS No:	<input type="text"/>		
Address:	<input type="text"/>		
Post Code:	<input type="text"/>	Year/Class	<input type="text"/>
Condition/Illness:	<input type="text"/>		

Medication

Name/Type of medication (as per dispensary label):
For how long will your child take this medication?
Date dispensed:
Dosage (amount) and method of administration:
Time(s) to be given:
Special precautions (if any):
Known side effects:

Self administration: Yes No

Procedures to take in any emergency:

Contact Information

Family Contact 1:

Name:

Home Telephone:

Work Telephone:

Relationship:

Family Contact 2:

Name:

Home Telephone:

Work Telephone:

Relationship:

Parental Agreement:

I understand that I must deliver the medicine personally to _____
(name of staff member receiving medication) and accept that this is a service which the
school is not obliged to undertake.

Signature: Date:

Name (print):

Relationship to Pupil:

Data Protection Act, 1998
The information that you supply on this form will be used by Children and Families Service for the purpose of maintaining and improving the level of service given for young people within Sandwell MBC. All information is regarded as confidential and any data collected via this form will be processed or disclosed only within the limits of the data protection notification. Data may be shared within Children and Families Service
For further information visit: [Department for Education](#)

Appendix 5

Confirmation of agreement for school to administer medication

I agree that (*name of child*) _____ Date of birth _____

will receive: (*quantity and name of medicine*): _____

every day at (*time(s) medicine to be administered*) _____

Delete one

* Medication will be given:

* Supervision will occur whilst he/she takes their medicine:

Delete one

* *Insert named member of staff:* _____

* *see attached list of staff*

Delete one

* This will continue until the end date of the course of medicine on _____

* This will continue until instructed by parents

Authorised School Signature:

Position:

Name: (print)

Date:

Signature of Parent/Carer:

Relationship to Child:

Name: (print)

Date:

A copy of this form should also be given to the parent.

