



Ysgol Comins Coch



REQUEST TO ADMINISTER MEDICATION

CHILD'S DETAILS

FULL NAME OF CHILD/YOUNG PERSON:

DATE OF BIRTH :

MALE / FEMALE

DETAILS OF MEDICATION

SYMPTOMS OF ILLNESS:

NAME OF MEDICATION (as on the container):

TYPE OF MEDICATION (liquid/tablet/):

HOW LONG WILL YOUR CHILD TAKE THIS MEDICATION:

START DATE:

(if known):FINISH DATE

DATE DISPENSED:

IS THE MEDICINE TO BE SELF ADMINISTERED Yes / No

DOSAGE TO BE ADMINISTERED:

METHOD OF ADMINISTERING (injection, swallowed etc):

FREQUENCY (e.g. twice daily – with times):

POTENTIAL SIDE EFFECTS:

HOW IS THE MEDICINE TO BE STORED:

IS THE CHILD TO CARRY THE MEDICINE WITH THEM DURING THE DAY: (please specify) Yes / No

ANY SPECIAL PRECAUTIONS REQUIRED WHILST ADMINISTERING THE MEDICATION: (please specify) Yes / No

CONTACT DETAILS OF PARENT /GUARDIAN AND ANY PROCEDURES TO TAKE IN AN EMERGENCY:

Work :

Home:

Mobile

DECLARATION I understand that I must give the medication to (The class teacher) and accept that it is a service which the school is **NOT** obliged to undertake.

PRINT NAME:

SIGNED

DATE:

RELATIONSHIP WITH CHILD

Other Information.

School Use

I acknowledge receipt of the above medication and agree that the child named above will receive the above medication as specified in the dosage and at the time agreed. They will be supervised whilst they take their medication and the arrangement will continue until the date the course of medicine has been completed.

In the case of emergency medicines stored at school the date this batch of Medication Expires

Name of Member of staff

Date