

MHCE REQUEST FOR ADMINISTRATION OF MEDICINES

My child has been diagnosed as suffering from

He / She is considered fit for school but requires the following prescribed medicine to be administered during school hours:

Pupil details

• Pupil Name	
• Class	
• Parent/Carer name	
• Contact number: home	
• Contact number: work	
• Contact number: home	
• Relationship to pupil	
• Name of medication / medication details	
• Dose and method of administration	
• With effect from	
• Duration of treatment [how many days] /last date of treatment	
• Special instructions / possible side effects	
• Emergency procedures	
• Who will administer the medication [signature to be included]	

Parent Declaration

- I understand that medication must be handed over by a responsible adult to a member of school staff.
- I understand that all staff are acting voluntarily in administering medicines and have the right to refuse to administer medication. I understand that the school staff cannot undertake to monitor the use of inhalers carried by children, and that the school is not responsible for the loss or damage to any medication.
- I confirm that the details given above are all correct and I give permission for a member of staff to administer the medication as per the dispensing label instructions.
- I undertake to update the school with any changes in administration for routine or emergency medication and to maintain an in-date supply of medication.
- Name (please print) _____ Date _____
- Signed _____

School Declaration

- I confirm that the school will administer the medication as agreed in the Administration of Medication Policy.
- Signed on behalf of the school _____ Date _____