

Request for school staff to administer prescribed, ad-hoc medication.

Child/Young Person’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Condition or illness (linked to this medication) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Medicine** |  |
| Name/type of medicine*(as described on the container)* |  |
| Expiry date |  |  |  |  |
| Dosage and method |  |
| Times of school day to be given |  |
| Route (eg oral/gastrostomy) |  |
| Special precautions/other instructions |  |
| Are there any side effects that the school needs to know about? |  |
| Self-administration – y/n |  |
| Start Date |  |
| End Date |  |
| Procedures to take in an emergency |  |
| **NB: Medicines must be in the original container as dispensed by the pharmacy****Contact Details** |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
| I understand that I must deliver the medicine personally to  | Transport Escort or School staff responsible for collecting medication |

The above information is, to the best of my knowledge, accurate at the time of writing.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to the child/young person

Signature Date