St Laurence School Request for Medicine Administration

The School will not give your child medicine unless you complete and sign this form.

Surname		Forename	
Address			
Date of Birth		Tutor Group	
Condition of Illness			
MEDICATION:			
Name/Type of Medication *(as described on the container)*			
For how long will your child take this medication?			
Date Medication dispensed			
FULL DIRECTIONS FOR USE:			
Dosage and method			
Timing			
Special Precautions			
Side Effects			
Self Administration			
Procedures to take in an Emergency:			
HAS YOUR CHILD BEEN PRESCRIBED AN EPI PEN?	□ YES □ No	If Yes, give details	
CONTACT DETAILS			
Name		Daytime tel no	
Relationship to student		Address	

I understand that I must deliver the medicine personally to the School Nurse and accept that this is a service which the school is not obliged to undertake.

Date		Parent/Carer Signature	

For School Use

Date	Time	Medication	Dose	Reaction	Signature