# Sacred Heart Catholic Primary School

## **ADMINISTRATION OF MEDICATION FORM**

Please note that the school will not administer medicine to your child unless you complete and sign this letter, and the headteacher has agreed that the school staff can administer the medication.

## Pupil Details

Surname:	 First Name
Date of Birth:	 Class:
Condition or Illness	 

### **Medication**

Name/Type of Medication (see container):			
How long will this me	dicine be administered?		
Dosage: ml	When:	AM/PM	Date dispensed:

The above medication(s) have been/have not been\* prescribed by a doctor. They are clearly labelled indicating contents, dosage and child's name in full. \* delete as appropriate

#### Contact Details

Name:	
Daytime Telephone Number:	
Mobile Telephone Number:	
Relationship to pupil:	

I understand that the medicine must be delivered personally to the school and that the school will only be able to administer the medicines if it can make the staff time available. I understand that I remain responsible for ensuring that my child receives medication and that I may have to make the necessary arrangements for its administration if the school is unable to.

Signed: .....

Date: .....

## FOR OFFICE USE ONLY

DATE	TIME	DOSAGE	DISPENSED BY