FORM MED 1

Request for School to Administer Prescribed Medication

I confirm that my child's doctor has stated that it is necessary for this medication to be taken in school and that I will notify the school, in writing, of any changes to this medication.

Date	Name of Child/Young Person	Form	Date of Birth

Medication

Name, strength and type of Medication	Dose	Route (Oral/ Gastrostomy etc)	Time	Duration of course	Method / Special instructions
Side effects and emergency procedures					

Contact Information

Name			
Phone No		Mobile No	

Medication must be

- supplied in the chemist's original container with a prescription sticker on
- clearly labelled with
  1. name of the medication
  2. child's name
  3. dosage
  4. expiry date
  5. any other directions (if applicable)

I…….(name)……(relationship to pupil) give consent for the school to administer the above medication to my child. I understand that without this consent, the school will be unable to administer the medication.

Signature……Parent/Carer Date…….

You have the right to withdraw your consent at anytime. Please notify the office in writing.