

SHERINGHAM WOODFIELDS SCHOOL
FORM: SWS MED 1

REQUEST FOR SCHOOL TO ADMINISTER PRESCRIBED MEDICATION

The school will not give your child medicine unless you complete and sign this form and the head teacher has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Name: DOB: Class:

Condition or illness:

MEDICATION

Name of medication	Duration of course	Dosage and method	Timing	Self administer Y or N	Date prescribed

Side effects from medication:

.....
.....

Emergency procedures:

.....
.....

CONTACT DETAILS

Name:

Address:
.....

Daytime telephone number:

DECLARATION

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

I confirm that my child's doctor has stated that (s)he considers it is necessary for the medication to be taken during school hours.

Signed: Date:

Relationship to pupil: