



Administration of Medication Form at Euxton Primrose Hill

Details of Pupil

Surname	<input type="text"/>	Forename(s)	<input type="text"/>
Address	<input type="text"/>		
Male/Female	<input type="text"/>	Class	<input type="text"/>
Date of Birth	<input type="text"/>	Condition/Illness	<input type="text"/>

Medication

Name/Type of medication (as described on the container)	<input type="text"/>		
Duration of course of medication	<input type="text"/>	Date dispensed	<input type="text"/>

Full Directions for Use

Dosage/Amount (as described on the container)	<input type="text"/>
Timing	<input type="text"/>
Side Effects	<input type="text"/>
Procedures to take in an emergency	<input type="text"/>

Contact Information

Name of Contact 1	<input type="text"/>	Name of Contact 2	<input type="text"/>
Relationship to pupil	<input type="text"/>	Relationship to pupil	<input type="text"/>
Telephone number(s)	<input type="text"/>	Telephone number(s)	<input type="text"/>

GP Information

Name of GP	<input type="text"/>	Telephone Number	<input type="text"/>
Allergies	<input type="text"/>		

I understand that I must deliver the medication personally to the school office and accept that this is a service which the school is not obliged to undertake. I understand that whilst every effort is made to ensure that my child receives their medication at the appropriate time it is my child's responsibility to come to the office and request their medication.

Signature: _____ Parent/Carer Date: _____