REQUEST FOR THE SCHOOL TO GIVE MEDICATION

Note: Medication will not be accepted until this form is completed in full and signed by the Parent or Carer of this student and administration of the medication is agreed by a member of the Leadership Team (LT).

Name of Student _____ Date of Birth_____

Class Group_____ Date of Request_____

Requested by **(please print name)** _____

Signature _____

Relationship to student_____

Address_____

_____

Contact Telephone Number_____

I request that the student named above be given the following medication at school.

Name of medication _____

Dosage to be given _____

Time of administration _____

For the following reason _____

_____

The GP / Consultant has **PRESCRIBED** this medicine and it is clearly labelled by the pharmacy indicating

- **Name of medication**
- **Dosage to be given**
- **The student's name in full.**

Please tick ☐

OR

This is a **NON-PRESCRIBED** medicine which I have purchased over the counter.
The medicine is supplied

- **in the original packaging with the information leaflet**
- **clearly labelled with the student's name in full.**

Please tick ☐

I understand that this medicine must be delivered personally, by the Parent / Carer/ Escort of the student, and handed directlyto the relevant Classroom Staff.
The medication must NOT travel in the student's bag/belongings.

Approved for Administration by LT **Date:**

Print Name

Signature

ORIGINAL to
CLASS TEACHER/
MEDICATION FOLDER

COLOUR COPY to
KATHLEEN BROWN

KB/July 2025