HOBART HIGH SCHOOL

Request for School to Administer Prescribed Medication

The school will not give your child prescribed medicine unless you complete and sign this form, and the Headteacher has agreed that a designated member of the school staff can administer the medication.

(Please ensure both sides of this form are completed)

DETAILS OF PUPIL

Surname:	Male/Female:
Forename(s):	Form:
Date of Birth:	Phone:
Address:	
Medical Condition or Illness:	

MEDICINE

Name/type of medicine *(as described on the container)*	
Expiry date	
Dosage and method	
Timing	
Special precautions/other Instructions	
Are there any side effects that the school/setting needs to know about?	
Self administration – y/n	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy.

PTO

Side effects from medication: _____

Emergency Procedures: _____

CONTACT DETAILS

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to:	(agreed member of staff)

DECLARATION

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature: _____ Date: _____

PLEASE ENSURE MEDICINE IS IN ORIGINAL PACKAGING AND CLEARLY MARKED WITH YOUR CHILD'S NAME