

Request for Barlow School to administer medication

PLEASE NOTE: We will not give your child medicine unless you complete and sign this form.

DETAILS OF CHILD:

Surname: Forename(s):.....

Address:..... M/F

..... Date of Birth:.....

Condition or illness:

MEDICATION:.....

Name/Type of Medication (as described on the container):.....

For how long will your child take this medication:.....

Date dispensed:.....

Full directions for use:

Dosage and method:.....

Timing:.....

Special Precautions:

Side Effects:.....

Self Administration:.....

Procedures to take in an Emergency:.....

CONTACT DETAILS:

Name: Daytime Telephone No:.....

Relationship to child:.....

Address:.....

.....

I understand that I must deliver the medicine personally to a member of staff and accept that this is a service which Barlow School is not obliged to undertake.

Date: Signature:.....

Relationship to child:.....

.....

Confirmation that Barlow School will agree to administer medication

I agree that (Name of child) will receive (quantity and name of medicine) every day at (time medicine to be administered).

..... (Name of child) will be given/supervised whilst he/she takes their medication by (Member of staff). This arrangement will continue until.....

Date:.....

Signed:.....