REQUEST FOR OAKTHORPE TO ADMINISTER MEDICATION

FORM FOR PARENTS/CARERS TO COMPLETE IF THEY WISH THE SCHOOL TO ADMINISTER MEDICATION

THE SCHOOL WILL NOT BE ABLE TO GIVE YOUR CHILD MEDICATION UNLESS YOU COMPLETE AND SIGN THIS FORM AND THE HEADTEACHER HAS AGREED THAT THE SCHOOL CAN ADMINISTER THE MEDICATION DETAILED.

Child's surname:	Child's first name:	
Child's address:		
Condition of illness:		
Female/Male:	Date of birth:	Class:

DETAILS OF MEDICATION:

Name/Type of medication (as described on the container)		
For how long will your child take this medication?		
Dosage:		
Once to be given in school at ……..time		
Self-administration under supervision? Yes/No		
Procedures to take in an Emergency:		
Your name:	Daytime telephone no:	
Relationship to pupil:		
Address:		
I understand that I must deliver the medication personally to …… at school. I accept that the administration of medication is a service which the school is not obliged to undertake and that in doing so, it is being done with my full consent. I accept that the school shall not be liable for any adverse consequences that may arise as a result of it undertaking this service.		
Print your name:	Signature:	Date: