SOUTHBOROUGH HIGH SCHOOL

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION FORM

All information given will be treated as strictly confidential

The School will not give your child medicine unless you complete and sign this form and the Head has agreed that school staff can administer it. **Please complete a separate form for each medicine.**

STUDENT DETAILS		
SURNAME		**TUTOR GROUP** (if known)
FORENAME		
DATE OF BIRTH		
CONDITION / ILLNESS		

MEDICATION	
Name/Type of Medicine (as described on container)	
For how long will your child take this medicine?	
Date dispensed	
Dosage and method	
Timing	
Special precautions	
Side effects	
Self- administration	
Procedure to take in an emergency	

I understand that the medicine must be delivered personally to a member of staff in the Administration Office, **in its original packaging**, with this form completed and signed. I will keep a record of the expiry date of any medication sent in to school and replace as necessary. I accept that this is a service which the School is not obliged to undertake.

PARENT/CARER NAME	
RELATIONSHIP TO STUDENT	
SIGNATURE	
DATE	

FOR OFFICE USE ONLY

Date request received by the School:	
Signature:	