NONSUCH HIGH SCHOOL FOR GIRLS

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

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		**Form:**
Forenames		
Date of Birth		
Condition/Illness		

MEDICATION	
Name/Type of Medicine (as described on container)	
Reason for giving this medicine (e.g for migraine or course of antibiotics)	
Dosage and method (? x 5ml, or ? x ?mg, not tab or spoonful)	
Expiry date	
Timing	
Special precautions	
Side effects	
Self administration	
Procedure to take in an emergency	

I understand that the medicine must be delivered personally to the Medical Room or a member of staff in the Administration Office and accept that this is a service which the School is not obliged to undertake.

PARENT/CARER NAME	
PARENT/CARER SIGNATURE	
RELATIONSHIP TO STUDENT	
DATE	

FOR OFFICIAL USE ONLY

Date request received by the School	