



REDNOCK SCHOOL

Request for school to administer medication

STUDENT DETAILS

Surname: _____

Forename: _____

Address: _____

Male | Female: _____

Date of Birth: _____

Tutor Group: _____

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: YES | NO

Procedures to take in an emergency: _____

EMERGENCY CONTACT DETAILS

Name: _____ Relationship to student: _____

Address: _____ Contact number: _____

I understand that I must deliver the medicine personally to main school reception. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature: _____ Date: _____