

Shevington High School Medicine Administering form

Date for review to be initiated by

Name of child

Date of birth

Tutor group

Medical condition or illness

Medicine

Name/type of medicine

(as described on the container)

Expiry date

Dosage and method

Timing

Special precautions/other instructions

Are there any side effects that the school/setting needs to know about?

Self-administration – y/n

Procedures to take in an emergency

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details

Name

Daytime telephone no.

Relationship to child

Address

I understand that I must deliver the medicine personally to

School Office

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school/setting policy. 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(s): _____ Date: _____