**Llanfair Primary School**

**Form 2: Parental request for education setting to administer medicine**

**Please complete and sign this form to request Llanfair Primary School to administer medicine.**

Name of child

 / /

Date of birth

Group/class/form

Healthcare need

**Medicine**

Name/type of medicine

(as described on the container)

 / /

 / /

Date dispensed Expiry date

Agreed review date to be initiated by Mr. R Jones

Dosage and method

Timing

Special precautions

Are there any side effects that

the setting needs to know about?

Self-administration (delete as appropriate) **Yes/No**

Procedures to take in an emergency

**Contact details**

Name

Daytime telephone no.

Relationship to child

Address

I understand that I must deliver the medicine personally to the school office or staff member

I understand that I must notify the setting of any changes in writing

I agree to the school discreetly displaying my child’s medical information to ensure staff are aware as required.

 / /

Date Signature(s) ………………………………………….........

**Office Use Only**

**School agrees to administer the above detailed medication to the named learner.**

**This will continue until the end of the course of medication or until instructed by parents/carers.**

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_