INGRAVE JOHNSTONE C OF E PRIMARY SCHOOL
REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Pupil's Full Name ……………………………………………….. ……………… Class …………

Address ……………………………………………………………………………………………

…………………………………………………………………………………………………….

Condition/Illness ………………………………………………………………………………

Name/Type of Medication ……………………………………………………………………….

……………………………………………………………………………………………………..

For how long will your child be required to take the medication? ………………………………………..

Date Dispensed ……………………… Frequency of Dosage ……………………………………………

Timing ………………………………. (Before Lunch/After Lunch)

Additional instruction/information: (e.g. before/after food, interaction with other medicines, possible side effects, storage instructions)

……………………………………………………………………………………………………..

……………………………………………………………………………………………………..

I understand that I must deliver the medicine personally to the office staff and collect any remaining medication when course completed.
I accept that the School has a right to refuse to administer medication.

Name ………………………………………………….. Relationship to child …………………………

Signed …………………………………………………. Date …………………………………………

School Use only:

Date	Time	Dosage	Signed	Date	Time	Dosage	Signed

This data will be stored on a computer. Ingrave Johnstone C of E Primary School fully complies with information legislation. For the full details on how we use your personal information please see the Privacy Notice in the Data Protection/GDPR section on our website or call 01277 810218 if you are unable to access the internet.