Avondale Primary School

for learning, smiling and remembering

Head Teacher
Mrs V Brown BA (Hons) QTS NPQH

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Request for the administration of medication during the school day

Date:	
Name of Pupil:	
Class:	
Parent/Carer's Name:	
Medication to be Administered:	
Amount to be Administered:	
Time to be Administered:	
Medication to be Administered By:	**Staff / Parent / Child**
Start Date of Medication:	
End Date of Medication	
Reason for Medication	
Does This Medication Need to be Stored in the Fridge?	**Yes / No**
Special Instructions (if any):	
Side Effects (if any):	
Emergency Contact Number	

I give consent for school staff to exercise parental responsibility on my behalf during the administration of medication to my child. I agree to inform the school staff immediately of any change in dosage and/or administration procedures and I will complete a new form when needed.

Signed (Parent/Carer)…… Name (print):…….

A copy of the school's medical policy is available on request.