**Challney High School For Girls**

**Administration of Medicines Request Form**

Staff will not administer medicines to your child unless this form is completed. Medicines **must** be supplied in their original packaging with the information leaflet and the dispensing label attached.

**Student Details**

|  |  |
| --- | --- |
| Name of student |  |
| Date of birth |  |
| Form group |  |
| Medical condition or illness |  |

**Medicine**

|  |  |
| --- | --- |
| Name/type of medicine  *(as described on the container)* |  |
| Date dispensed |  |
| Expiry date |  |
| Dosage instructions |  |
| Are there any side effects that the  school needs to know about? |  |

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 policy.

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

I clearly understand and accept that medicines will not be administered unless this form is completed and resubmitted annually (for long-term conditions).

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Details**

|  |  |
| --- | --- |
| Name |  |
| Daytime telephone number |  |
| Relationship to student |  |