Winchelsea School

Parental Request for the Administration of Prescribed Medication – Form M2

CHILD'S NAME: ………………………………………………………………………………… CLASS: …………………………………

CHILD'S DATE OF BIRTH: ……………………………………………………………………….

Name (Parent/Carer)……………………………………………………………………………………… (***please print Parent/Carer name)***
Request that the prescribed medication described below should be administered to my child:

Reason for medication:

……
……

Name (brand/generic):

……
……

Type of medication (i.e. tablet, liquid & cream):
……

Dose: …………………………………………………**Strength**: …………………………………………………**Quantity**: ………………………………………

At the time/times stated: ……

Times/frequency: ………

Start/Finish Dates or Ongoing: ……

Special instructions: ……

Storage*: 1. Fridge 2. Medical Cupboard *(*please circle as appropriate)*

Administered*: 1. Orally 2. Injection 3. Topically (to the skin) 4. Rectally (**please circle as appropriate)*

Patient Information Leaflet included (P.I.L): **YES / NO** *(please circle as appropriate)*

Are you aware of any known side effects your child may experience with this medication? If yes, please list:
……
……

Name, address and telephone number of Doctor/practice prescribing the medication:

……

……

Signed: ………………………………………………………………… (Parent/Carer) Date: ……………………………………………………………

Print Name: …………………………………………………………………

Daytime contact telephone number: ………

Should your child refuse medication, the school cannot take any further action and the medication <u>will not</u> be administered. Should this happen, you will be contacted immediately by telephone.