



Coleraine Grammar School

Request for a School to Administer Medication

The school will not give your child medicine unless you complete and sign this form, and the Headmaster has agreed that school staff can administer the medicine.

Details of Pupil	
Surname	Forename(s)
Address	
Postcode	
Date of Birth	Year / Class
Condition / Illness	
Medication Parents must ensure that only medication which is in date and properly labelled is supplied. Name / Type of Medication (as described on the container)	
Date dispensed:	Expiry date:
Full Directions for Use	
Dosage and method	
NB Dosage can only be changed on a Doctor's instructions	
Timing	
Special Precautions	
Are there any side effects that the school needs to know about?	

Self Administration Yes / No (*delete as appropriate*)

Procedures to take in an Emergency

Contact Details

Name:

Phone No Home / mobile:

Work:

Relationship to pupil

Address

I understand that I must deliver the medicine personally to _____
(*agreed member of staff*) and accept that this is a service, which the school is not
obliged to undertake. I understand that I must notify the school of any changes in
writing

Signature:

Date:

Print Name

Agreement of Principal

I agree that _____ (*name of pupil*) will receive
_____ (*quantity & name of medicine*) every day at
_____ (*time(s) that medicine is to be administered e.g. lunchtime*).

This child will be given their medication / supervised whilst they take their medication
by _____ (*name of staff member*).

This arrangement will continue until _____ (*either end date
of course of medication or until instructed by parents*)

Signature:

Date:

(*The Headmaster / authorised member of staff*)

**The original form will be retained on the school file and a copy will be sent to
the parents to confirm the school's agreement to administer medication to the
named pupil.**