Request for Administration of Medicines/Treatment

The Priory Primary Academy Trust

Name of Pupils…….

Address…….

……..

Parent Contact Numbers……..……

GP…….. Telephone No……..…...

Please tick the appropriate box below:

☐ My child will be responsible for self administration of medicines as directed below

☐ I agree to members of staff administering medicines/providing treatment to my child as directed below or in case of an emergency, as staff consider necessary

Name of Medicine	Dose	Frequency/times	Completion date of course	Expiry date of medicine

Special Instructions……..…..…

Allergies…….

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Other prescribed medicines child takes at home……....

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All medicines are to be left in the care of the Administration Assistant. There is no provision for medication that requires refrigeration.

Signed……. Date…….