

**Appendix 4****Request for school to administer medication**

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

Child's Surname:			
Forename(s):			
DOB:		M <input type="checkbox"/>	F <input type="checkbox"/>
NHS No:			
Address:			
Post Code:		Year/Class	
Condition/Illness:			

**Medication**

Name/Type of medication (as per dispensary label):

For how long will your child take this medication?

Date dispensed:  
Expiry date:

Dosage (amount) and method of administration:

Time(s) to be given:

Special precautions (if any):

Known side effects:

Self-administration:

Yes

No

Procedures to take in any emergency:

**Contact Information**

**Family Contact 1:**

Name:

Home Telephone:

Work Telephone:

Relationship:

**Family Contact 2:**

Name:

Home Telephone:

Work Telephone:

Relationship:

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**Parental Agreement:**

I understand that I must deliver the medicine personally to .....  
(name of staff member receiving medication) and accept that this is a service which the  
school is not obliged to undertake.

Signature: ..... Date: .....

Name (print): .....

Relationship to Pupil: .....

**Data Protection Act, 1998**

The information that you supply on this form will be used by Children's Services for the purpose of maintaining and improving the level of service given for young people within Sandwell MBC. All information is regarded as confidential and any data collected via this form will be processed or disclosed only within the limits of the data protection notification. Data may be shared within Children's Services

**For further information visit: [Department for Education](#)**