To be completed where the school is required to administer medication to a child during school hours

**SCHOOL MEDICATION POLICY FORM**

|  |  |
| --- | --- |
| **Child’s name** |  |
| **Class** |  |
| **Date of Birth** |  |

|  |  |
| --- | --- |
| **Doctors name** |  |
| **Surgery address**  |  |

|  |  |
| --- | --- |
| **Name of medication**  |  |
| **Dose** |  |
| **Time to be given**  |  |
| **Date of last dose required** |  |

Does this medication need to be kept in the fridge? Yes No

I understand it is my responsibility to supply the school with medication in properly labelled

containers and the medication is in date.

I accept that whilst my child in the care of the school, staff may need to arrange medical

intervention considered necessary in an emergency and that I will be told of such actions as

soon as possible.

I request treatment be given in accordance with the above information by a responsible

member of the staff who has received the necessary training.

|  |  |
| --- | --- |
| **Signature**  |  |
| **Relationship to child**  |  |
| **Date** |  |