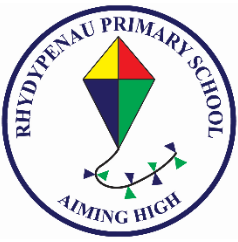

Rhydypenau Primary School

Request for the Administration

of Prescribed Medication

Pupil Name: ……………………………………………………………………

Year Group/Class: ……………………………………………………………………

I hereby request that my child receives the following medication.

Name of medication: ……………………………………………………………………

For the treatment of: ……………………………………………………………………

Amount of medication required (dosage): ……………………………………………………………………

Time to be administered: ……………………………………………………………………

Expiry date (if known): ……………………………………………………………………

Duration of treatment: ……………………………………………………………………

I absolve the school of all responsibility whilst administering the above-named medication of my child or forgetting to administer the above-named medication.

Parent/Carer Name: ……………………………………………………………………

Relation to Pupil: ……………………………………………………………………

Emergency Contact Information: ……………………………………………………………………

Please indicate if the above telephone number needs to be changed on the school system

Yes ( ) or No ( )

Signed Parent/Carer: ……………………………………………………………………

Date: ……………………………………………………………………

Authorisation:

Staff Member (Office Team): ……………………………………………………………………

Signature: ……………………………………………………………………

Date: ……………………………………………………………………

For office use only

Name of Medication	Amount Given (eg. 5mls/1 tablet)	Administered by	Witnessed By	Time & Date	Staff Initials