

**REQUEST FOR SCHOOL TO ADMINISTER MEDICATION**

**DETAILS OF PUPIL**

CHILD'S NAME: \_\_\_\_\_ CLASS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I authorise the medication listed below to be administered to the above named child by staff of Morgans School.

**MEDICINES MUST BE IN ORIGINAL PACKAGING WITH APPROPRIATE DOSING INSTRUMENT**

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason for this medication to be given: \_\_\_\_\_

I give permission for this medicine to be administered from:

(Date): \_\_\_\_\_ to \_\_\_\_\_

Medication Expiry Date (if applicable) \_\_\_\_\_

I understand that I must deliver the medicine personally to the school office and accept that Morgans School staff can refuse to administer medication if it is not correctly packaged and not correctly identifying my child.

I understand that whilst all best efforts will be made, staff of Morgans School accept no responsibility whatsoever for omitting to administer this medicine or administering the medicine at a time different from that specified above.

Signed: \_\_\_\_\_ (Parent/Carer)

Date: \_\_\_\_\_