Shaftesbury Park Primary School
Headteacher: Mrs Bunmi Richards
Ashbury Road, London
SW11 5UW
Tel: 020 7228 3652 Fax: 020 7223 0584
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REQUEST FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

Name of Pupil ____

Date of Birth ____

1) Name of medication ____

Dosage (how much) ____________ Frequency (how often) ____________

To be given: (please circle)

BY MOUTH / BY INHALATION / APPLIED TO SKIN / EYE DROPS / EAR DROPS

2) Name of medication ____

Dosage (how much) ____________ Frequency (how often) ____________

To be given: (please circle)

BY MOUTH / BY INHALATION / APPLIED TO SKIN / EYE DROPS / EAR DROPS

Please state any precautions or possible side effects

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Signature of parent or guardian ________________________

Name in Print ________________________ Relationship________________

Date ____________

Members of staff agreeing to the above responsibility should be satisfied that enough information and instruction is provided to allow the procedure to be carried out safely

Signature of member of staff accepting request: ______________________________
Date:___________________________

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