FAIRFAX
SINCERITAS LABORIS

REQUEST FOR ADMINISTRATION OF MEDICINE

Student's details:

Forename:…… Surname:……

Date of Birth:……. Form:…… Year group:……

About the Medication:

Name of Medication:……

Type of Medication:……..

Reason for Medication:……..

Date Dispensed:……Expiry Date:……..

Dosage required:……Frequency:……..

……

Please note: All prescribed medicine must be in its original container with the label intact

Record of Administration

Date	Time	Dosage	Signature		Date	Time	Dosage	Signature

(Continued overleaf)

I, the parent/carer of the above named child give permission for the school staff to supervise my child in administering the above listed medicine on my behalf. I understand that the school staff are acting on the information supplied and therefore cannot be held responsible if the medication is administered incorrectly.

I will inform the school immediately if there is any change in the dosage or frequency of the medicine.

Parent/Carer (Please print Name):……

Signature:……Date…….

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Date	Time	Dosage	Signature	Date	Time	Dosage	Signature