REQUEST FOR ADMINISTRATION OF MEDICINE

Name: …… Class: …….

G.P.: ……. G.P. Phone No:……..

MEDICINE TO BE GIVEN FOR _____(ILLNESS)

MEDICINE IS _____

Dosage and method:
……..

Time: ……..
Side effects:
……..

Any special instructions:
……..

I would like a member of staff to administer on my behalf the above medicine. I accept that they are acting on my instructions and they cannot be held responsible if the medicine is not given or given wrongly. I will inform the school immediately if there is any change in the dosage or frequency of the medicine.

Parent/Guardian Signature: ……

Record of administration:

	Date	Time	Dose	Signature		Date	Time	Dose	Signature
1					**11**				
2					**12**				
3					**13**				
4					**14**				
5					**15**				
6					**16**				
7					**17**				
8					**18**				
9					**19**				
10					**20**				

Allergy Pink **Inhalers** Blue **Other** White
Diabetes Green **Epilepsy** Yellow