

**RAYLEIGH PRIMARY SCHOOL**  
**REQUEST FOR SCHOOL TO ADMINISTER MEDICATION**

Pupil's Full Name: ..... Class: .....

Address: .....

Condition/Illness: .....

Name/Type of Medication: .....

For how long will child be required to take medication? .....

Date Dispensed: .....

Frequency of Dosage: ..... Timing .....

Additional Instructions/Information (eg before/after food, interaction with other medicines, possible side effects, storage instructions)

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Emergency Contacts:

Name: ..... Relationship to Child:.....

Daytime telephone/mobile number: .....

OR

Name: ..... Relationship to Child: .....

Daytime telephone/mobile number: .....

I understand that I must deliver the medicine personally to a member of the school office and collect any remaining medication when course completed. I accept that the school has a right to refuse to administer medication.

Name: ..... Relationship to Child: .....

Signed: ..... Date: .....

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**School Use:**

Remaining medication returned to parent on: .....

or disposed of via: ..... on: .....

Signed: .....

Authorised. PL.