**Short Term Medication Request Form**

Staff at Petersfield School will only give your child medicine (**which must be prescribed by a doctor**) if you complete and sign this form. If more than one medicine is to be given, a separate form must be completed for each one. There is a policy for the administration of medicine which staff must adhere to for your child’s safety.

Name of child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Class: \_\_\_\_\_\_\_\_\_\_\_

Medical condition or illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicine**

Name/type of medicine (as described on prescription label):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date dispensed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry date: \_\_\_\_\_\_\_\_\_\_\_

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

Timing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of final dose: \_\_\_\_\_\_\_\_\_\_\_

Are there any side effects that the school needs to know about?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self administration? Yes/No (delete as appropriate)

**Note: *Medicines MUST be in the original container as dispensed by the pharmacy. Only an adult may deliver medicine to the school and collect it if required. Medication will not be accepted from children or given to children to take home. Parents are responsible for ensuring that medication is in date.***

**Contact Details**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime telephone numbers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is, to the best of my knowledge, accurate and I give my consent to school staff administering medicine in accordance with the school policy and my child’s care plan. I will inform the school immediately, in writing, if there is any change in dosage or frequency, or if the medication is stopped.

**If my child has had medication before school, I will notify the school office of time and dosage so that further medication can be administered safely. I consent to this information and any individual health care plan being shared with medical professionals where appropriate (for example in an emergency situation or setting).**

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