



EDUCATION SERVICES

WISTON PRIMARY SCHOOL - Head Teacher Mrs E McGregor

**ADMINISTRATION OF MEDICINES
PARENTAL REQUEST FORM**

The school will not give your child medicine unless you complete and sign this form.

Details of Pupil

Surname: _____ Forename(s): _____

Address: _____

Date of Birth: _____ M F

Class: _____

Condition or illness: _____

Medication

Name/Type of Medication (as described on the container)

For how long will your child take this medication?

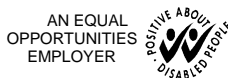
_____ Date dispensed: / /

Full directions for use: _____

Dosage and method: _____

Timing: _____

Biggar ML12 6HT Telephone 01899 850634 Facsimile 01899 850298



Special Instructions:

Special Precautions: _____

Side effects: _____

Self Administration: _____

Procedures to take in an Emergency

- Parents must ensure that in date properly labelled medication is supplied.

Contact Details

Name: _____

Daytime telephone number: _____

Relationship to Pupil: _____

Address: _____

I understand that I must deliver the medicine personally to a member of staff and accept that this is a service which the school is not obliged to undertake.

Signature(s): _____ Date: / /

Relationship to Pupil: _____