ADMINISTER MEDICATION REQUEST FORM

ST. ANTONY'S CATHOLIC PRIMARY SCHOOL

TO BE COMPLETED BY PUPIL PARENT OR GUARDIAN

Please use **BLOCK CAPITALS** and only **BLUE** or **BLACK** INK.

PUPIL DETAILS

SURNAME OF PUPIL:	**FIRST NAME(S) OF PUPIL:**	
ADDRESS:		
GENDER: MALE/FEMALE	**AGE:**	**CLASS:**
MEDICAL CONDITION OR ILLNESS:		
NAME OF MEDICINE ***(as described on the container):*** ***NB: Medicines must be in the original container as dispensed by the pharmacy***		
DOSE: **TIME TO ADMINISTER:** *(if applicable)*	**DURATION OF ADMINISTRATION** **FROM:**	**TO:**

PARENT/GUARDIAN DETAILS

NAME OF PARENT OR GUARDIAN:	**RELATIONSHIP TO PUPIL:**
ADDRESS: *(if different from above)*	
TEL: (DAYTIME)	**TEL: (EVENING)**

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

SIGNATURE:	DATE: