Request for Portchester Community School's

Medical Room to administer medication

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

Details of Student:

Surname: _____

Forename(s): _____

Address: _____ _____

Date of Birth: _____ Tutor: _____

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: _____

Storage: _____

Timing: _____

Special Precautions: _____

Side Effects: _____ Self Administration: _____

Medicine to stay in school or to go home at the end of the day: Stay in school: ☐ Return home: ☐

Procedures to take in an Emergency: _____

Contact Details:

Name: _____ Daytime Telephone No. _____

Relationship to Student: _____

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

Signature: _____ _____ Date: _____