# Houston Primary School

**Administration of Medicines: Parental Request Form**

Name of Child _____ Class _____

Date of Birth _____

Name of Medicine _____

Dosage _____

Timings _____

Possible Side Effects_____

Name of General Practitioner _____

Address _____

_____

Telephone Number _____

I confirm that my child (NAME) _____ requires the above stated medication to

treat _____ and it can be administered by a **non** medically qualified person or be self-administered.

I can confirm that the first dose has been administered by the parent/guardian.
I confirm that a parent/guardian will collect the medicine once it is no longer required or at the end of each school day.
Children are **not** permitted to carry medicine.

Date and time when given _____

Home Address _____

_____

Home Telephone Number _____

Signature of Parent/Guardian _____ Date _____

| **Review of Medication** | | |
|---|---|---|
| ○ Medication Suitable for Current Condition<br>○ Expiry Date Checked<br>○ Appropriate storage conditions (e.g. fridge)<br>○ Dosage Checked | ○ Medication Suitable for Current Condition<br>○ Expiry Date Checked<br>○ Appropriate storage conditions (e.g. fridge)<br>○ Dosage Checked | ○ Medication Suitable for Current Condition<br>○ Expiry Date Checked<br>○ Appropriate storage conditions (e.g. fridge)<br>○ Dosage Checked |
| Signature of Parent/Guardian<br>_____<br>Date _____ | Signature of Parent/Guardian<br>_____<br>Date _____ | Signature of Parent/Guardian<br>_____<br>Date _____ |