



Short term request to administer medication

Kept in school for?i.e daily/weekly	
Name of school/setting	Holy Trinity Lamorbey CE Primary School
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine	
Expiry date	
Dosage and time required	
Time of last dosage given if applicable	
Are there any side effects?	
Self-administration – y/n	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Medication received by	

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

Parent Signature(s).....

Date.....

Head Teacher signature-----

Date-----

Name:

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Healthcare Plan Ref:

HTL Record of medicine administered to an individual child

Date				
Time given				
Dose given				
Staff signature				
Staff initials				

Date				
Time given				
Dose given				
Staff signature				
Staff initials				

Date				
Time given				
Dose given				
Staff signature				
Staff initials				

Date				
Time given				
Dose given				
Staff signature				

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Staff initials

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