

**Wandsworth Borough Council – Education Department**

**Request for administration of medication in schools.**

**N.B.** This form is provided in the interests of staff and pupils, in accordance with legal requirements and good practice.

**(Please complete form in BLOCK capitals)**

Name of pupil/student: \_\_\_\_\_

Date of birth: \_\_\_\_\_

1. Name of medication: \_\_\_\_\_

Dosage (how much) \_\_\_\_\_ Frequency (how often): \_\_\_\_\_

To be given: **(please delete as appropriate)**

By mouth / By Inhalation / Applied to skin / Eye drops / Ear drops

Please state nature of illness and any precautions or possible side effects of medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Name of medication: \_\_\_\_\_

Dosage (how much) \_\_\_\_\_ Frequency (how often): \_\_\_\_\_

To be given: **(please delete as appropriate)**

By mouth / By Inhalation / Applied to skin / Eye drops / Ear drops

Please state nature of illness and any precautions or possible side effects of medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Name in print: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_

Member of staff agreeing to the above responsibility should be satisfied that enough information and instruction is provided to allow the procedure to be carried out safely.

Signature of Staff member accepting request \_\_\_\_\_ Date: \_\_\_\_\_