Mayflower High School

Headteacher: Mr Damian Lee

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Student Name: ..... **Tutor Group:** .....

Name / Type of Medication: .....

Condition / Illness: .....

Is this medication prescribed by your Doctor? YES/NO (Please delete accordingly)

For how long will student be required to take medication: .....

Date dispensed: ..... **Dose:** .....

Frequency of Dosage: ..... **Timing:** .....

Additional instructions/information (eg before/after food, possible side effects, interaction with other medicines, storage instructions):

.....

.....

I understand that I must deliver the medicine personally, or send it with my child, to Reception, replace any medication used and collect any remaining medication when the course is completed. I accept that the School has a right to refuse to administer medication and that it is my responsibility to ensure that all medication is within the expiry date and to inform the School of any drug changes.

Name: ..... Relationship to student: .....

Signed: ..... Date: .....

NB: Drugs/Medicines sent to school MUST be in current pharmacy-labelled containers.

School use:

Remaining medication returned/finished course/disposed (circle accordingly)

Date:

STOCK ROAD · BILLERICAY · ESSEX · CM12 0RT · TELEPHONE: 01277 623171 · FACSIMILE: 01277 632256
Email: educate@mayflowerhigh.essex.sch.uk · WEB: www.mayflowerhigh.essex.sch.uk
Company Number: 07692668

DRUG DISPENSING RECORD SHEET

Name of Student: _____ Tutor Group _____

DRUG	PRESCRIBED YES/NO	DOSE	DATE	TIME	INITIALS

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