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| **FORM MP3****REQUEST FOR SCHOOL TO ACCEPT MEDICATION** | School Crest |

|  |  |
| --- | --- |
| Child’s Name: |  |
| Form Class: |  |
| Date of Birth: |  |
| Medical condition or illness: |  |

**MEDICATION**

**Parents must ensure that in date properly labelled medication is supplied.**

|  |  |
| --- | --- |
| Name/type of medicine:(*as described on the container*) |  |
| Date Dispensed: |  |
| Expiry Date: |  |
| Agreed review date to be initiated by: | (name of member of staff) |
| Dosage and method: |  |
| *(NB Dosage can only be changed on a Doctor’s instructions)* |
| Timing: |  |
| Special Precautions: |  |
| Are there any side effects that the school needs to know about: |  |
| **Self administration**: |  |
| Procedures to take in an emergency: |  |

CONTACT DETAILS

|  |  |
| --- | --- |
| Name: |  |
| Daytime telephone number: |  |
| Relationship to child: |  |
| Address: |  |
|  |  |

I accept that this is a service that the school is **not** obliged to undertake.

I understand that I must notify the school of any changes in writing.

Signature(s): …………………………………………………… Date: ……………………….

 …………………………………………………… Date: ……………………….

**CONFIRMATION OF THE PRINCIPAL’S AGREEMENT TO ADMINISTER MEDICINE**:

I agree that ……………………………………………….(*child’s name*) will receive ……………………………………………… (*quantity and name of medicine*) in the event of an emergency.

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

 Principal / authorised member of staff