Appendix 2

Biddenham International School & Sports College

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Student's Name:		**Tutor Group:**	
Address:			
Condition/Illness:			
Name of Medication:			
Type of Medication:			
How long will the student be required to take medication:			
Date tablets received:			
Dose:			
Frequency of Dose:			
Timing:			
Additional instructions/information: (e.g. before/after food, interaction with other medication, possible side effects, storage instructions)			

I understand that I must deliver the medicine personally, or send it with my child to the First Aider in the Sanctuary, 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 Sanctuary of any drug changes.

Name (please print): …… Date: ……..……...
(Parent/Carer)

Relationship to the above named student: ……

N.B: drugs/medicines sent to school MUST be in current pharmacy labelled containers.

School use: Remaining medication returned to parent/carer on (insert date): ……..

Or disposed of on (insert date): ……..