PMR1

ALDER GRANGE SCHOOL
PUPIL MEDICATION REGISTER

The school will not give your child any medication unless this form is completed and signed and the Head teacher or Authorised Personnel have agreed that school staff can administer the medication.

Has your child any medical condition/illness which school need to be made aware of.

Yes_____ No_____

If YES complete and sign the following form, if NO just sign and return.

Name of pupil: _____ Date of Birth: _____ Form: _____

Condition or Illness: _____

Does any medication need to be administered in school: _____ If yes please complete below.

Information for Medication administered in school	
1. Name of medication (as described on the container)	
2. Dosage and amount (as described on the container)	
3. Dosage timing	
4. Method - mouth/drops etc	
5. How long will the child be on the medication	
6. Any special requirements e.g. before food etc.	
Other information	
1. Special precautions	
2. Side effects	
3. Administration self/member of staff	
4. Procedures to be taken in an emergency	

CONTACT DETAILS:
Name: _____ **Daytime telephone no:** _____

Relationship to pupil: _____

Address: _____

I understand that I must deliver the medication personally to authorised school staff and accept that this is a service which the school is not obliged to undertake. Please return to Student Services Officer

Date: _____ Signature: _____