WOODLANDS PRIMARY ACADEMY
Creative Education Trust

MEDICINE FORM

Request for Academy Staff to administer medication

Full Name of Pupil ……

Class …….. **Age ……..**

Address ……..……..……

……

Contact Telephone Number ……..……

Condition/Illness ……..

Name of Medication ……

Dose to give ……..……..

MEDICATION WILL BE GIVEN AT LUNCHTIME UNLESS STATED OTHERWISE BY A DOCTOR

How long will he/she be required to take the medication? …….

Mon ☐ **Tue** ☐ **Wed** ☐ **Thur** ☐ **Fri** ☐

Please note that all medicines must be supplied unopened in the original packaging or tablet blister packs with the child's name clearly visible.

I understand that I must ensure safe delivery of the medicine to the Academy and arrange collection of any remaining medication when the course is completed. I accept that the Academy has a right to refuse to administer medication.

Signed Parent/Guardian …….. Date ……

Name of Parent/Guardian ……

Relationship to Pupil ……

For Academy Use Only

Remaining medication returned to parent/guardian on (date) ……..……

Date medication sent for disposal (date) Signed ……..……..……

Pupil Name	Class

Date	Time	Medication	Dose	Comments	Signature