ST ALBANS
SCHOOL

**REQUEST FOR SCHOOL NURSE TO ADMINISTER PRESCRIPTION MEDICATION**

To be completed by parents if they wish the School Nurse to administer medication

NAME……...……

FORM……...……

ILLNESS/CONDITION……...……...……
PRESCRIBED MEDICINE …… (must always be supplied in its original packaging with the pharmacy label attached)

DOSAGE TO BE GIVEN……

TIMES TO BE GIVEN……

NUMBER OF DAYS TO BE GIVEN……

TO BE KEPT IN FRIDGE YES/NO……...……

SELF ADMINISTRATION YES/NO……

CONTACT DETAILS OF PARENT

NAME……

TELEPHONE NO…… *

IT IS THE PUPIL'S RESPONSIBILITY TO COME TO THE MEDICAL ROOM FOR HIS/HER MEDICATION

* SIGNATURE OF PARENT/GUARDIAN…… DATE…..……..……..

VIVIENNE BLACKMAN RGN
SALLY GREEN RGN RSCN
CHRISTINA RUSSELL RGN