APPENDIX 2

MED2

REQUEST FOR MEDICATION TO BE SELF ADMINISTERED

This form must be completed by parents/carers of pupils under 16

1. DETAILS OF PUPIL

Pupil's name: _____ Date of birth: _____

Address: _____

_____

_____

School: _____ Class _____

Tel No: Home: _____ Emergency: _____

2. DETAILS OF MEDICATION

Condition or illness: _____

Name/Type of medication
(as described on the container) _____

Prescribed by: (please tick as appropriate)

☐ GP Name: _____

Address: _____

☐ Hospital Name: _____

Address: _____

☐ Other Name: _____

Address: _____

For how long will your child take this medication? _____

Full directions for use: .....

Dosage and method: .....

Times at which medicine(s) to be given: .....

Special precautions: .....

Side effects: .....

Expiry Date: .....