Sacred Heart Primary
Administration of Medicines

Natus Ad Patrare
Born to Achieve

Glasgow
CITY COUNCIL

Parental Request Form

Name of Pupil	
Class	
Date of Birth	
Name of Medicine	
Type of Medication Tablet, syrup etc.	
Dosage/Timing	
Name Address Telephone Number of Doctor	

I confirm that my child _____ requires the following medicine(s) and that it can be administered by a non-medically qualified person.
I will also undertake to inform the head immediately of any changes in the medication and will provide an appropriately labelled separate supply.

Signature of Parent/Guardian _____ Date _____

Home Address _____

_____

Telephone Numbers Home _____ Work _____
Mobile _____

Emergency Contact Name _____
Home Address _____

_____

Telephone Number(s) Home _____ Mobile _____