## Beams of Light

## Request for administration of medication

**This form is provided in the interests of staff and pupils, in accordance with legal requirements and good practice.**

**(Please complete form in BLOCK capitals)**

Name of pupil: _____

Date of birth: _____

1. Name of medication: _____
   Dosage (how much) _____
   Frequency (how often) _____
   To be given: (please delete as appropriate)
   By mouth/ By inhalation/ Applied to skin/ Eye drops/ Ear drops

Please state the nature of illness and any precautions or possible side effects of medication

_____

_____

2.Name of medication: _____

Dosage (how much) _____
Frequency (how often) _____
To be given: (please delete as appropriate)
By mouth/ By inhalation/ Applied to skin/ Eye drops/ Ear drops

Please state the nature of illness and any precautions or possible side effects of medication

_____

_____

Signature of parent or guardian:_____ Date:_____

Name in print:_____ Relationship: _____

Member of staff agreeing to the above responsibility should be satisfied that enough information and instruction is provided to allow the procedure to be carried out safely.

Signature of staff member accepting request: _____

Name in print: _____ Date:_____