building a healthy future

CITY OF WOLVERHAMPTON COUNCIL

The Royal Wolverhampton NHS
NHS Trust

Form M4

Request to school for administration of Non Prescribed medication (Over the counter medication)

The school will not give your child medicine, or allow self-administration of medication, unless you have completed and signed this form, and school have given you a photocopy of this form.

DETAILS OF PUPIL

Surname _____ Forename _____

Condition or illness _____

Class/Form _____

MEDICATION FROM PHARMACY/SUPERMARKET

Medication/Type of Medication (as described on the container)

_____

How long will your child take this medication: _____

Date commenced _____

Medication expiry date

Full directions for use by Walk-in Centre/Out of hours Professional As appropriate

Name.....

Status.....

Signature.....
Date.....
Pin.....

Dosage and method _____ Timing _____

Special Precautions _____

Side Effects _____

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FOR SCHOOL STAFF

Who will keep the medication? School ☐ Pupil ☐

Self Administration Yes ☐ No ☐

Procedures to take in an Emergency:

CONTACT DETAILS

Family Contact 1		Family Contact 2	
Name		Name	
Phone No (work)		Phone No (work)	
Home		Home	
Mobile		Mobile	
Relationship		Relationship	

I understand that I must deliver the medicine personally to (agreed member of staff) and accept that this is a service which the school is not obliged to undertake.

Date _____ **Relationship to pupil** _____

Signature(s) _____

It is agreed that_____ **(name of the child) will receive the medication detailed above.**
The arrangement will continue either to the end of the course or treatment as advised by health professional

Name:_____ **(Member of Staff)**

Signed:_____**Date**_____

Copies of Forms Sent to: