

**LEYLAND METHODIST JUNIOR SCHOOL**  
**SUPPORTING PUPILS WITH MEDICAL NEEDS IN SCHOOL**

**DETAILS OF PUPIL**

Surname: \_\_\_\_\_

Forename: \_\_\_\_\_

Address: \_\_\_\_\_ M/F: \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Class: \_\_\_\_\_

Condition or Illness: \_\_\_\_\_

**MEDICATION**

Name/Type of Medication (*as described on the container*) \_\_\_\_\_

\_\_\_\_\_

For how long will your child take this medication: \_\_\_\_\_

Date Dispensed: \_\_\_\_\_

**FULL DIRECTIONS FOR USE:**

Dosage and amount (*as per instructions on container*): \_\_\_\_\_

Method: \_\_\_\_\_

Timing: \_\_\_\_\_

Special Precautions: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Self Administration: \_\_\_\_\_

Procedures to take in an emergency: \_\_\_\_\_

I understand that I must deliver the medication personally to the school office and accept that this is a service which the school is not obliged to undertake.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to pupil: \_\_\_\_\_