

**MED2**

**REQUEST FOR MEDICATION TO BE SELF ADMINISTERED**

This form must be completed by parents/carers of young persons under 16.

**1. DETAILS OF CHILD**

Child'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 ✓

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) should be given:  
 .....

Special precautions: .....

Side effects (if any): .....

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

Special precautions: .....

Side effects (if any): .....

Procedures to be taken in an emergency: (e.g. asthma – maximum number of doses to be administered for treatment of acute wheezing?)

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**3. PARENTAL RESPONSIBILITY**

- (i) I would like my daughter/son to keep her/his medication on her/him for use as necessary.
- (ii) I understand that I must deliver the medicine(s) personally to you and to replace them wherever necessary.

Delete (i) or (ii) as appropriate.

Signature of parent/carer: ..... Date .....

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Date received by Establishment.....

Head of Establishment's Signature  
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ACTION TAKEN
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