



REQUEST FOR THE SCHOOL TO GIVE MEDICATION

Date _____

Child's name: _____ Date of birth: _____ Class: _____

Medical condition or illness: _____

I request that my child be given the following medicine(s) while at school:

Name/type of Medicine: _____ (as described on container)

Duration of course: _____ Expiry date: _____

Dosage and method: _____ Time(s) to be given: _____

Other instructions: _____

Self administration Yes/No (mark as appropriate)

The above medication has been prescribed by the family or hospital doctor, it is clearly labelled indicating contents, dosage and child's name in FULL. Yes/No (mark as appropriate)

Name and telephone number of GP: _____

I understand that I must deliver the medicine personally and accept that this is a service that the school is not obliged to undertake. I understand that I must notify the school of any changes in writing.

Signed: _____ Print Name: _____ (Parent/Guardian)

Address: _____

Daytime telephone number: _____ Date: _____

Note to parents:

- 1. Medication will not be accepted by the school unless this form is completed and signed by the parent or legal guardian of the child and the administration of the medicine is agreed by the Headteacher.**
- 2. Medicines must be in the original container as dispensed by the Pharmacy.**
- 3. The agreement will be reviewed on a termly basis.**
- 4. The Governors and Headteacher reserve the right to withdraw this service.**