LOWER PEOVER C E PRIMARY SCHOOL
REQUEST FOR THE SCHOOL TO GIVE MEDICATION

I request that ……..… (Full name of Pupil) be given the following medicine(s) while at school:

Date of birth ..…… Class ……

Medical condition or illness …….

Name/Type & Expiry Date of Medicine…….
(as described on container)

Start Date of administration……. Duration of course…..…….

Dosage and method …… Time(s) to be given……....

Time of dose administered at home (if applicable)……

Other instructions ……..

Self-administration Yes/No (mark as appropriate)

The above medication has been prescribed by the family or hospital doctor (Health Professional note received as appropriate). It is clearly labelled indicating contents, dosage and child's name in FULL.

Name and telephone number of GP …….

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

Signed ……..……Print Name ……
(Parent/Guardian)

Date …… Daytime telephone number ……...

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 that 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 Governors and Headteacher reserve the right to withdraw this service**