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

Dear Headteacher,

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 of Medicine
……..……(as described on container)

Number of tablets/sachets ……

signed…….. (member of staff and parent)

Expiry date ……..... Start date ……

Duration of course …….……

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 (Health Professional note received as appropriate). It is in the original packaging and 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 (agreed member of 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)

Daytime telephone number
……

Address ……
…….

Note to parents:

1. Medication will not be accepted by the school unless this form is complete 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. Tablets or sachets must be counted out in front of named member of staff countersigned for.
4. The agreement will be reviewed on a termly basis.
5. The Governors and Headteacher reserve the right to withdraw this service.