CAPENHURST C.E. PRIMARY SCHOOL

REQUEST FOR THE SCHOOL TO GIVE MEDICATION

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

Please complete 1 sheet per medicine - if applicable

Name of Medicine .....

It is clearly labeled indicating contents, dosage and child's name in FULL.

Duration of course ……..

Dose Prescribed ……..

Date Prescribed …….. Expiry Date ……

Day	Time given	Time given	Administered by (completed by School – please print name)	Any other notes
Monday	am	pm		
Tuesday	am	pm		
Wednesday	am	pm		
Thursday	am	pm		
Friday	am	pm		

(Please cross out below which-ever does not apply)
- The above medication has been prescribed by the family or hospital doctor.
- The above medication has been prescribed by the Parent

I understand that the medicine must be delivered to the school by myself or the under-mentioned responsible adult.

.....

and accept that this is a service which the school is not obliged to undertake and also agree to inform the school of any change in dosage immediately.

Signed: ..... **Parent/Guardian**

Print Name: .....

Address: .....

.....

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Date: .....

Notes 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 This agreement will be reviewed on a termly basis.
3 The Governors and Headteacher reserve the right to withdraw this service.