REQUEST FOR THE SCHOOL TO GIVE PRESCRIBED MEDICATION AT SCHOOL:

Name of pupil ……**Year group** ……**Date of birth**……..…..

Medical condition or illness……..…..

Name/type of **Prescribed** Medicine (must match container)……

Expiry date…… Duration of course…..……Dosage ……..……

Other instructions …….

Name and telephone number of GP ……

Self-administration Yes/No (mark as appropriate)

I confirm that 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.
I understand that I must deliver the **prescribed** medicine personally to the School Office 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.

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

Date …… Daytime telephone number ……

Address ……..……..

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

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Section for Member of Staff Receiving Medication to complete:

When receiving medication and before administering medication please make the following checks and sign to show you have done this:

- ☐ I have checked the pupil's name matches the name on the form and the name on the dispensing label.
- ☐ I have checked that the medication matches the medication on the consent form.
- ☐ I have checked that the medication is in date.

Name:_____Signed:_____Date:_____