



Great Budworth CE (A) Primary School

REQUEST FOR THE SCHOOL TO GIVE MEDICATION

Dear Head Teacher,

I request that (full name of pupil) be given the following medicine(s) when at school.

Date of Birth..... Class/Year Group

Medical condition or illness

Name/type of medicine (as described on container)

Expiry date Duration of course

Dosage & Method Time(s) to be given

Other instructions

Can this medicine be self-administered? Yes No (circle as appropriate)

The above medication is clearly labelled indicating contents, dosage and the child's name in FULL.

Name and telephone number of GP

I understand that I must deliver the medicine(s) personally to school 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 Name Signature

Daytime telephone number

Address

Date

Note to Parents:

1. Medication will not be accepted by the school unless this form is completed and signed by the parent/legal guardian of the child and that the administration of the medicine is agreed by the Head Teacher.
2. Medicines must be in their original container.
3. The agreement will be reviewed on a termly basis.
4. The Governors and Head Teacher reserve the right to withdraw this service.