

## REQUEST FOR MEDICINE TO BE GIVEN IN SCHOOL

The school will not give your child medicine unless you complete and sign this form, and the medicine delivered personally to a designated member of staff.

**ALL PRESCRIBED MEDICINES MUST BE PROVIDED IN THE ORIGINAL PACKAGING AS DISPENSED BY A PHARMACIST**

Thank you.

Child's Name.....

Date of Birth ..... Class .....

Medical condition or illness .....

Medication.....

Dose to be given.....

Time of day to be given .....

How many days to be given.....

Possible side effects if any .....

Storage (please tick)      Cupboard .....      Fridge .....

Child's GP Surgery.....

### Parent Agreement

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent/Carer Name .....

Parent/Carer Signature ..... Date .....

Daytime telephone .....

## Everybody Matters, Everybody Succeeds

