

MEDICATION FORM

I request that my child – (Name)

(Class)

Be given the following medication

Name of medicine(s)

Dosage **Time**

1) The above medicine has been prescribed by the family doctor (in original packaging with child's name printed).

2) The medication is clearly labelled indicating contents, dosage, child's name in full and class attended.

3) I understand that the medicine must be delivered personally to Mrs Brett (KS1) or Mrs Bown (KS2) – and accept this is a service that the school is not obliged to undertake.

4) I agree that the school will not accept this medication if this form is not completed in full and the school has agreed its administration.

5) A prescription dosage of 3 times a day is usually taken at home before, after and at bedtime.

Signed **Parent/Guardian**

Date **Emergency tel no**

The Governors and Head Teacher reserve the right to withdraw this service.