



Winwick CE Primary School

REQUEST FOR THE SCHOOL TO GIVE MEDICATION

I request that _____ (name of pupil) be given the following medication while at school.

Name of Medicine	Duration of Course	DOSE Prescribed & Frequency to be Taken	Date Prescribed	DATE & TIME OF LAST DOSE GIVEN THIS MORNING:	Day and Time(s) to be given:				
					BREAKFAST CLUB	AM	LUNCH TIME	PM	LINK CLUB
SCHOOL USE Administered / Observed by: Signed – Members of Staff:									
SCHOOL USE Administered / Observed by: Signed – Members of Staff:									
SCHOOL USE Administered / Observed by: Signed – Members of Staff:									
SCHOOL USE Administered / Observed by: Signed – Members of Staff:									

The above medication has been prescribed by the family or hospital doctor. It is clearly labelled indicating contents, dosage and child’s name in full and is in its original packaging with correct implement for administering the medication dosage.

I understand that the medicine must be **delivered to the school by a parent** or the **adult named below** and handed to a member of school staff. **Adult delivering medication:** _____

I 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. I **give permission** for a member of school staff to administer the medication detailed above and/or to supervise my child taking their medication (if this is usual practise).

Signed: _____ **Name:** _____
(Parent/Carer)

Date: _____

Note: Medication will not be accepted by the school unless this form is completed and signed by the Parent or Legal Guardian of the child. The Governors and Headteacher reserve the right to withdraw this service.