

Brookhurst Primary School

REQUEST FOR THE SCHOOL TO GIVE MEDICATION

I request that be given the following medicine(s) while at school:
 (Full name of Pupil)

Year group

Date of request.....

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

Any adverse reactions to this medicine previously? Yes/No (mark as appropriate)

Only medication that has been **prescribed** by the family doctor or hospital doctor will be administered in school. It must be clearly labelled indicating contents, dosage and child's name in FULL.

Name and telephone number of GP

I understand that I must deliver and collect the medicine personally to and from the school office and accept that this is a service that the school/setting is not obliged to undertake. I understand that I must notify the school/setting of any changes in writing.

Signed Print Name

Daytime telephone number

Date and Time	Amount	Administered by	Counter Signatory