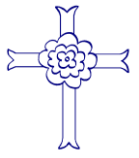


ST THERESA'S CATHOLIC PRIMARY SCHOOL



REQUEST FOR THE SCHOOL TO ADMINISTER MEDICATION

Dear Head Teacher,

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

Date: _____

Date of birth: _____

Year/Class: _____

Medical condition or illness: _____

Name/type of Medicine:
(as described on container) _____

Expiry date: _____

Duration of course: _____

Dosage and method: _____

Time(s) to be given: _____

Other instructions: _____

Self administration: Yes / No (mark as appropriate)

The above medication has been prescribed by the family or hospital doctor (Health Professional note received as appropriate). It is clearly labelled indicating contents, dosage and child's name in FULL.

Name and telephone number of GP: _____

Surgery Address: _____

I understand that I must deliver the medicine personally to the class teacher, 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.

Signed: _____ Print Name: _____ (Parent/Guardian)

Daytime telephone number: _____ Or _____

Address: _____

Head Teacher Agreement: _____ Date: _____

Note to parents:

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