

ST THOMAS MORE RC PRIMARY SCHOOL

REQUEST FOR THE ADMINISTRATION OF MEDICINES

To: Headteacher of: School

From: Parent/Carer of:..... Full name of child

Date of birth:.....

My child has been diagnosed as suffering from:.....

..... Name of illness

He/She is considered fit for school but requires the following prescribed medicine to be administered during school hours.....Name of medicine

Could you therefore please administer.....(dosage) at (time)

With effect from.....(date) to*(date)*

*Delete if long term medication

***The school CANNOT be responsible for ensuring medication is administered at a particular time. If the timing is essential PARENTS MUST make arrangements to come to school at the appropriate time.**

The medicine should be administered by mouth **/ in the ear ** / nasally ** / other **

(please specify)**.....

** Delete as appropriate

I understand that all staff are acting voluntarily in administering medicines and have the right to refuse to administer medication. I understand that the school staff cannot undertake to monitor the use of inhalers carried by children, and that the school is not responsible for loss or damage to any medication.

I undertake to update the school with any changes in administration for routine or emergency medication and to maintain an in-date supply of the medication.

Signed:..... Date:.....

Name of Parent/Carer:..... (Please print)

Name of Child:..... (Please print)

Contact Details: Telephone No. (Home).....

(Work).....

(Mobile).....