EXCALIBUR PRIMARY SCHOOL

REQUEST FOR THE SCHOOL TO GIVE MEDICATION

Dear Headteacher									
I request that	(Full 1	name of pupil) Date of Bir	th:						
	g medicine(s) while at school:	,	••••••••••••						
Name of Medicine		Duration of Course							
Dose Prescribed		Date Prescribed							
Time(s) to be given		Date/Time Last Dosage							
Expiry Date		Storage Details	Fridge/No Fridge						
indicating contents, d	n has been prescribed by the fan losage and child's name in FUL medicine must be delivered to the	L.	•						
school of any change	a service which the school is not in dosage immediately.	-							
Telephone/Contact N	umber								
Address if different f	rom above:	•••••	••••						
Date:	•••••								
G.P. Name:									
Address:									
Telephone No:									
Notes to Payonts									

Notes 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. This agreement will be reviewed on a termly basis.
- 3. The Governors and Headteacher reserve the right to withdraw this service.

		Countersignature of person witnessing dosage				Manufacture and a second and a				
Medicine should be administered from the original container or by a monitored dosage system such as a blister pack. The designated member of staff should not sign the medicine record book unless they have personally administered, assisted, or witnessed the administration of the medicine.	Signature of member of giving dose									
	If medicine not given reasons why?									
	Date/time and dosage administered									
	Person/s responsible for administering dosage									
	Details of Dosage	A. A								
	nave personally administe	Medicine Prescribed								
ine should be	unless they	Date of Birth								
<u>oipain</u>		Name of Child								