ST. GABRIEL'S CATHOLIC PRIMARY SCHOOL

REQUEST FOR THE SCHOOL TO GIVE MEDICATION (Prescribed/Non-Prescribed

Dear Headteacher

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

Date of birth: ..... Class: ..... Today's Date: .....

Medical condition or illness .....

Name/type of Medicine .....
(As described on container)

Duration of course: Start date..... End Date.....

Please tick days to be given:

MON	TUE	WED	THURS	FRI

Dosage Prescribed: .....

Time(s) to be given.....

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 .....

I understand that I must deliver and collect the medicine at the end of the day personally to the school office 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. I confirm my child has never had an adverse reaction to this medication.

Signed ..... Name .....
(Parent/Guardian)

Daytime telephone number .....

Address .....

.....

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