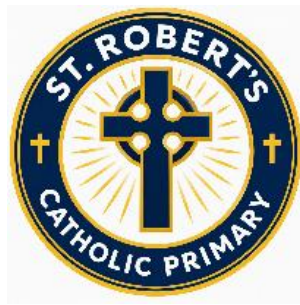




REQUEST FOR THE ADMINISTRATION OF PRESCRIBED MEDICINE IN SCHOOL

Name of child _____

Date of birth _____ Class _____

I request that the above-named child should receive:

Name of medicine _____

Dose of medicine _____

Time(s) of administration _____

Duration of treatment _____

Possible side-effects _____

☐ Signed _____ (parent/guardian)

Name of Parent/Guardian _____

Address _____

Contact No _____

Authorised _____ (head teacher)

Date _____

☐ Whilst every effort will be made to adhere to the doses and times noted above, St. Robert's Catholic Primary School will not be held responsible should any error occur, and that in any case, where doubts or queries arise, no medicine will be administered before satisfactory confirmation is received from parent(s)/guardian.