

**REQUEST FOR REGULAR PRESCRIBED MEDICINES TO BE ADMINISTERED IN SCHOOL**

In order for your child to receive medicines at school, please would you complete, sign and return this form at the start of EACH term or where there is any change in the prescribed medicine.

Medicines can only be administered if there is a completed and signed consent (request) form.

<b>Child's Name:</b>		<b>DOB:</b>	<b>NHS No:</b>	
<b>Allergies:</b> (if no allergies please write 'None')	<b>Dietary Restrictions:</b> (if no dietary restrictions please write 'None')		<b>Last known weight:</b>	<b>Class:</b>

<b>Name of Medicine</b>	<b>Strength of Medicine</b>	<b>Form</b> e.g. tablets, syrup, cream	<b>Dose</b> as prescribed	<b>Time</b> to be administered	<b>How is the medicine given</b> e.g. mouth, feeding tube	<b>Comments</b> e.g. any special method or preferred way of taking medication

Medicines may only be administered in school from the original container labelled with full instructions dispensed by the pharmacist. Please check that the medicine is in date and has not gone beyond the expiry date.

All medicines must be delivered to the school in person or given directly to the school transport escort in a green pharmacy bag.

**Signed, Parent/Guardian:** ..... **Print Name:** ..... **Date:** .....

**Contact Telephone Number:** .....

**Request received by School Nurse on(Date)..... School Nurse signed .....Print Name.....**