## THAMESIDE PRIMARY SCHOOL

Letter to be signed by parents:

**REQUEST FOR THE SCHOOL TO GIVE MEDICATION**

Child's name _____

Date of birth _____ Class/Form _____

Address _____

_____

Parent's Telephone Numbers Home _____ Work _____

GP _____ Tel No _____

Please tick the appropriate box

☐ My child will be responsible for self-administration of medicines as directed below.

☐ I agree to members of staff administering medicines/providing treatment to my child as directed below or in case of an emergency, as staff consider necessary.

Signed _____ Date _____
(Parent/Guardian)

| Name of medicine | Dose | Frequency/ times | Completion date Of course if known | Expiry date of Medicine if app |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Special instructions | | | | |
| Allergies | | | | |
| Other prescribed medicines child takes at home | | | | |

NOTE: Medication will not be accepted in the school unless this letter is completed and signed by the parent or legal guardian of the child, and the administration of the medicine is agreed by Mrs Harrop or Mrs Cooper in the school office.

NOTE: The Headteacher reserves the right to withdraw this service.