Form 2: Request for school to issue short-term prescribed medication in school

To be completed by the parent/carer

Pupil's name	Date of birth

I request that the above pupil be given the following medication while at school. I have given the first dose of this medication to my child and no adverse reaction has been observed.

Name of medication	Date prescribed	Dose to be given	Minimum time between doses	Medication to be given if the following symptoms occur

The GP or hospital doctor has prescribed the above medication. It is in the container in which it was dispensed, clearly labeled with the contents, dosage and child's name in full.
I realise that this is not a service that the school is obliged to undertake. I accept full responsibility for informing the school if my child has been given a dose of this medication before coming to school. I accept responsibility for ensuring that the medicine has not expired and that there will be enough medicine supplied to the school for my child's needs. I will collect any unused medication at the end of the period the medication is prescribed for.

Parent/carer's name (please print)	
Address	☎ Home
	☎ Work
	☎ Mobile
@	
Name of G.P.	
Address of G.P.	☎ G.P.
Signature of Parent/Carer	Date

Note: The school will not accept medication unless this form is completed and signed by the parent/carer of the pupil and the head teacher agrees the administration of the medication. The head teacher reserves the right to withdraw this service.