St Michael's CE Primary School

Headteacher: Miss J Matthews

Prescribed Medication Request

Name of Child: _____ Class: _____

Please give my child _____ of _____
(Dose) (Medication)

at _____am _____pm for _____ days.

Signed: _____ (Parent/Guardian).

I understand that I must deliver the medication to Ms Ahmed at the school.

I accept that the administration of medication is a service which the school is not obliged to undertake and that, in doing so, it is being done with my full consent.

I accept that the school shall not be liable for any adverse consequences that may arise as a result of it undertaking this service.

Signed: _____ Date: _____

Relationship to pupil: _____

Medication Given									
	Date	**Time**	**Initial**	**Date**	**Time**	**Initial**	**Date**	**Time**	**Initial**
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									