

Appendix A

Sefton Park Schools

REQUEST FOR THE SCHOOL TO GIVE MEDICATION

Name of pupil	
Date of birth	
Year group and class	
Medical condition or illness	
Name of medicine(s) as described on container	
Expiry date and duration of course	
Dosage and method	
Time(s) to be given	
Other instructions	
Any known allergies	
Any other medication being taken by child?	

**The above medication has been prescribed by a doctor. It is clearly labelled indicating contents, dosage and child's name in full**

Name and telephone number of GP.....

**Over-the-counter medication agreed by**.....

Signed (Parent/Carer) .....

Print name.....

Daytime contact number.....

Address.....  
.....  
.....

**Medication will not be accepted by the school unless this form is completed and signed by the parent or legal guardian and that the administration of medication is agreed.**

**Medicines must be in the original container as dispensed by the Pharmacy.**