ADMINISTRATION OF SHORT TERM COURSE OF MEDICINE

Child's Name:	
Date Treatment Started:	
Expected end date:	

NAME OF MEDICATION:	DOSE:	TIME/S:

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

☐ I understand that I am responsible for providing clearly labelled, in date medicine, delivered personally to the school office. The school does not accept liability if staff forget to administer it at a set time, the office is busy during the day and ultimately it is the parent's responsibility to see that the course of medication is administered as directed.

⇒ Signed: (parent/guardian) Date:

Medication will not be accepted in the school unless this letter is completed and signed by the parents or legal guardian of the child and the administration of the medicine is agreed by the Headteacher. The Headteacher reserves the right to withdraw this service.

Date	Time	Staff Signature	Date	Time	Staff Signature

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