**EAST RENFREWSHIRE COUNCIL**

**EDUCATION DEPARTMENT**

**REQUEST FOR THE ADMINISTERING OF MEDICINES**

**IN EDUCATIONAL ESTABLISHMENTS**

To the Head Teacher

I request that:

|  |  |
| --- | --- |
| Full name of pupil |  |
| Date of Birth |  |
| Class |  |

be given the following medicine(s) whilst at school:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medical Condition or illness |  | | | |
| Name/Type of Medicine (as described on container) |  | | | |
| Expiry date |  | | | |
| Duration of course |  | | | |
| Dosage and method |  | | | |
| Time(s) to be given |  | | | |
| Other comments |  | | | |
| Self-administration (delete as appropriate) | Yes |  | No |  |
| Name and telephone number of GP |  | | | |

The above medication has been prescribed by the family or hospital doctor (Health Professional note received as appropriate). It is clearly labelled indicating contents, dosage and child’s name in FULL.

I understand that I must deliver the medicine personally to the school and accept that this is a service that the school is not required to provide. I understand that I must notify the school of any changes in writing.

|  |  |
| --- | --- |
| Print Name (Parent/Carer) |  |
| Signed |  |
| Date |  |
| Telephone Number | Email Address |
| Address |  |