COMHAIRLE NAN EILEAN SIAR 

EDUCATION, SKILLS AND CHILDREN’S SERVICES

LEVERHULME MEMORIAL SCHOOL

PARENTAL REQUEST FOR ADMINISTRATION OF MEDICINES

**To: Head Teacher of Leverhulme Memorial School**

I wish my child ………………………………………………………………………………………………**(name)**

 **(DOB):** ……………………………………………………………

to have the following medicine administered by school staff as indicated until …………………..….. ***(date of completion)***

**Name of Medicine:** ………………………………………………………………………

**Reason for taking Medicine:** ………………………………………………………………………

 ………………………………………………………………………

This medicine has been prescribed by self/doctor ***(delete as appropriate)***

Time(s) at which medication is to be given: …………………………………………………………………….

Dosage ***(and means of administration if applicable)***: ………………………………………...................

………………………………………………………………………………………………………………………………………………..

I undertake to deliver the medicine personally to the school, to replace it whenever necessary, and to dispose of any unused medicine after completion of the course. I also undertake to advise you immediately of any change of treatment.

**Signed:**  ………………..……………………………………………………………… **(Parent/Guardian)**

**Name in Print:** ………………………………………………………………………………..

**Date:**  ………………………………………