**Blisworth Community Primary School**

**Prescribed Medicine Administration Request Form**

Name of Pupil …………………………………………………………………….. Class …………………………………

I authorise a member of staff at Blisworth CP School to give my child the medicine as listed below and accept full responsibility for this. I will arrange for an adult to deliver the medicine to the school office and collect the medicine at the end of the school day.

**Please note: *children should not be asked to deliver or collect the medicine themselves***

Signed ……………………………………………………………….. Dated …………………………………………………

 Parent/Carer

Name of Medicine …………………………………………………………………………………………………………….

Storage Requirements ………………………………………………………………………………………………………

(eg. Refridgeration)

Time/s medicine needs to be taken ……………………………………………………………………………………

(eg. Before/after lunch)

Dosage ……………………………………………………………………………………………………………………………….

(eg. Spoonfuls/ml)

Dates/Days this week that the medicine is required:

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

**For Staff Completion Only (please complete each time medicine is given)**

|  |  |  |
| --- | --- | --- |
| **Date** | **Time** | **Signature** |
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