Brookfields
Specialist SEN School

REQUEST FOR THE SCHOOL TO GIVE MEDICATION

PUPILS NAME: ……..

ADDRESS: …….

DATE OF BIRTH: ……..

1. Name/type of medication:……..
   Purpose of medication:……
   Dosage:…….
   Time to be given: …….
   Special Instructions: ……..

2. Name/type of medication:……..
   Purpose of medication:……
   Dosage:…….
   Time to be given: …….
   Special Instructions: ……..

3. Name/type of medication:……..
   Purpose of medication:……
   Dosage:…….
   Time to be given: …….
   Special Instructions: ……..

CONTACT DETAILS: PARENT/GUARDIAN

Name:.....
Daytime telephone number: .....
Relationship to pupil:……..

I request that a member of staff administer the above medications(s). I will inform school staff immediately of any medication changes.

- Regular medication to be given in school must be prescribed by a doctor.
- **Medication must be in the original bottle as dispensed by the pharmacist.**
- **Medication must be current and dated and it must have the child's name on it.**

Signature .....
Print Name .....
Date .....

Location of medication in school:

PLEASE RETURN TO COMMUNITY SCHOOL NURSE AT BROOKFIELDS SCHOOL.

Checked/signed: …….

THE HEADTEACHER RESERVES THE RIGHT TO WITHDRAW THIS SERVICE.