Churnet View
Middle School

Parental/Carer Request For School to Administer Medication

The school will not administer your child's medicine unless you fully complete and sign this form. Where possible, medicines should be prescribed in dose frequencies which enable them to be taken outside of school hours.

DETAILS OF PUPIL

Surname:_____ Forename:_____

Date of birth:_____ Form:_____

Condition/illness:_____

MEDICATION

Name (as described on the container):_____

Dosage:_____ Expiry date:_____

For how long will your child take this medication? _____ Self administration? _____

CONTACT DETAILS

Name:_____ Relationship to pupil:_____

Telephone number(s):_____

Signature of parent/carer with parental responsibility_____

Please print name:_____ Date:_____

By signing this I accept responsibility for school staff to administer non-prescribed and prescribed medication according the above instructions.

Received by:_____ Date:_____

Headteacher: Mr S D Fryer
Churnet View Leek Staffordshire ST13 6PU. Tel: 01538 384939
Email: cvm.office@ttlt.org.uk Website: cvm.ttlt.org.uk