

# THE PIGGOTT SCHOOL



## CONSENT TO ADMINISTER 'TEMPORARY' MEDICATION

(Prescription or Parental Requested)

Name of Pupil..... Tutor Group.....

Name of Medicine	Dosage	Dates & Times to be given

NB – Medicines MUST be in the original container as dispensed by the pharmacy

1. *My son/daughter has taken this medication before*       Yes       No
2. *My son/daughter can self-administer his/her medication*       Yes       No

I understand that it is my son/daughter's responsibility to go to Student Services/First Aid at the time their medication is due and that I must inform Student Services/First Aid of any changes in writing immediately they come into effect.

Signed.....(Parent/Guardian) Relationship to student.....

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

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