# The Piggott School: Charvil Primary

## REQUEST FOR THE ADMINISTRATION BY THE SCHOOL OF PRESCRIBED ASTHMA MEDICATION

To the Headteacher

I request that ……(full name of child)

Year group …… be given the following prescribed medication:

…….(name of medicine)

…….. (dosage)

If the medicine is to be given at specific times, please specify fully the time and

frequency: ……..

**Otherwise, I agree that the medication is administered when needed.**

**Only medication which has been prescribed by a Doctor can be administered. It should have the prescription label indicating contents, dosage and child's name in FULL.**

I understand that the medicine must be delivered by an adult to school reception. I accept that this is a service which the school is not obliged to undertake.

Signed …….. Parent/Guardian

Emergency Telephone No ……Date ……..

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| **NOTE:** | **Medication will not be accepted by the school unless this letter is completed and signed by the parent or legal guardian of the child and the administration of the medicine is agreed by the Headteacher.**<br>The Headteacher reserve the right to withdraw this service at any time. |

I have administered the stated dosage of medication to the child named overleaf.

| Date | Time | Dose | Initials | Date | Time | Dose | Initials |
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