

# Chiswick & Bedford Park Preparatory School

## Request for Administration of Medicines

From: Parent/Carer of.....Full Name of Child.

My child has been diagnosed as suffering from:.....  
(name of illness)

He/She is considered fit for school but requires the following medicine to be administered during school hours:.....  
(name of medicine)

Could you please therefore administer.....(dosage)

Needs Refrigeration: Yes/No (Please delete as applicable)

The medicine should be administered by mouth/in the ear/nasally/other.  
(Please specify).

With effect from:.....(date)

To:.....(date)

- I am aware that medicines will be administered between 11.50am and 12.00noon.
- I have ensured that the medicine is clearly labelled with my child's name and Form.
- I confirm that I am responsible for the collection of any medication at the end of the day.

I understand that staff are acting voluntarily in administering medicines. I understand that the school is not responsible for loss or damage to any medication.

Signed:..... Date:.....

Name of Parent/Carer:.....(Please print).

Medication administered at:.....(time & date)

By:.....(Member of Staff)

Witnessed by:.....(Member of Staff)