

# STAINES PREPARATORY SCHOOL

## CONFIDENTIAL MEDICAL INFORMATION REQUEST TO ADMINISTER MEDICATION

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CHILD'S NAME .....CLASS.....

PARENT'S NAME .....

NAME OF MEDICATION .....

DOSAGE AT SCHOOL .....(Compulsory/Optional)

TIME OF DAY TO BE ADMINISTERED .....

CONDITION BEING TREATED .....

.....

I, the parent of the child named above, request that the medication named above is administered at the stated times.

I understand that although the School will endeavour to administer the medicine according to the instructions given, no responsibility can be accepted if a dose is late or missed.

Signed ..... Date .....

### CONTINUATION OF CURRENT MEDICINE:

Date:.....Time already taken:..... Time to be given..... (Comp/Opt)  
Sig:.....

Date:.....Time already taken:..... Time to be given..... (Comp/Opt)  
Sig:.....

Date:.....Time already taken:..... Time to be given..... (Comp/Opt)  
Sig:.....

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Sig:.....

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Sig:.....