Equivalent Form 3B

St Louis Catholic Primary School

PRESCRIBED MEDICATION FORM (Long Term)

To the Head Teacher
St Louis Catholic Primary School

My child ……. In Year ……

has been prescribed ……..medication for the following

reason: …… The dosage is as follows: ……

……..

Expiry date of medicine: …… No of tablets/quantity given to school: ……

Name and Phone Number of GP: …….

It has been prescribed by a doctor and is required to be administered during school hours. It is clearly labelled indicating contents, dosage and the child's name in FULL.

I understand that:

a) The medication must be delivered personally to the school and in its
b) original container.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

Parent/Guardian Signature: ……

Address: …….

…….

Postcode: ……. Date: ……..

Contact Telephone Number: …….
The Head Teacher reserves the right to withdraw this service.

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For office use Ref No: ……..

Agree to administration of medicines YES/NO

If NO, reason given: …….

Staff Signature:.. ……. Date:…. ……..