



Please hand this form together with the medicine to the class teacher/ the school nurse/ the secretary before school starts.

Name of child:

Class:

is able to follow lessons but requires the following medicine during school hours:

Name of Medicine:

Method and Dose:

When to be given:

Storage requirements:

Medicines must be in the **original container as dispensed by the pharmacy.** Please add a **label** with your **child's name** as well as the **address and telephone number of the prescribing GP.**

N.B. School staff can **not** be held responsible for any consequences arising from the administration of medicines in school. The prime responsibility remains with the parents.

Prescribing G.P./ doctor Parent:

Date: Date:

Stamp and signature: Signature: