Administration of Medicines in Landulph School

NAME OF PUPIL……

Address…….

……..

……..

……..

Medical Condition of pupil……..

…….

Medicine……..

…….

Dose……Frequency of dose……

I confirm that the above medicine has been prescribed by a doctor and that I give my permission for the Headteacher (or his/her nominee) to administer the medicine to my son/daughter during the time he/she is at school.

Signed…….. (Parent/Guardian)

Date……..