WISTASTON CHURCH LANE ACADEMY





PLEASE READ THIS FORM BEFORE SIGNING. ONLY SOMEONE WITH PARENTAL RESPONSIBILITY CAN SIGN THIS FORM.

I accept this is a service which the school is not obliged to undertake and the Principal and Local Advisory Board reserve the right to withdraw it. I understand that the school will make every effort to ensure correct instructions are followed. I understand that the medicine must be delivered to the school by myself or one of the named responsible adults for my child. I agree to inform the school immediately of any change in dosage. A separate form must be completed for each medication and for each prescription.

A separate form must be	e completed [·]	for each	n medication and for e	ach pre	scription.	
Name of child						
Class						
I request that the above						
The medicine below has	been prescri	bed by	a doctor, dentist or pr	escribir	ng medical prof	essional.
Medicine						
Times and dosage of medicine:						
Relevant side effects to observed, if any	o be					
administered		From (first day)				
		To (last day)				
I understand that I must supp a pharmacist and will provide plastic container. I understand that this medica	e no more than	a 10-day	supply of said medication.	. Ideally I	will put the medic	ation inside a named
Signature		Relationship to child			Phone Number	
Date 1	Гime given		Dose given	Memb	per of staff	Initials

Date	Time given	Dose given	Member of staff	Initials

Administration of Prescribed Medication Continuation Sheet

Name of child	
Class	

Date	Time given	Dose given	Member of staff	Initials