



Ashby Hill Top Primary School

An Academy School

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Administering of Medicines in School

FROM: Parent/Guardian of Full Name of Child

DATE:

My child has been diagnosed as suffering from(name of illness).

He/She is considered fit for school but requires the following prescribed medicine to be administered during school hours (name of medicine). _____

Could you please therefore administer _____ (dosage) at _____(time) with effect from _____ (date) to* _____ (date)* inclusive

The medicine should be administered by mouth** / in the ear ** / nasally ** / other ** (Please specify)

* Delete if long term medication

** Delete as appropriate

I understand that all staff are acting voluntarily in administering medicines and have the right to refuse to administer medication. I understand that the school cannot undertake to monitor the use of inhalers carried by children, and that the school is not responsible for loss or damage to any medication.

I understand it is my child's responsibility to remember to go to the medical room at the right time for the medication.

I undertake to update the school with any changes in administration for routine or emergency medication and to maintain an in date supply of the medication.

Further instructions:

Signed(parent/ guardian)

Name of Parent/Guardian(please print)

