



The Winchcombe School

REQUEST FOR THE SCHOOL TO GIVE MEDICATION

Dear Headteacher,

I request that (Full Name of Child) of

.....Class

Be given the following medication:

Name of Medicine:

Dosage:

At the following time/s:

Frequency :

Until (Date):/...../20..... (No later than end of academic year)

[] The above medicine(s) have been prescribed by a doctor and copy of certificate is attached and is clearly labelled with child's name, dosage and contents

OR

[] The above medicine(s) have been purchased for limited treatment

Signed Parent/Guardian

Print Name.....

Date.....

NOTE Medication will not be accepted in school unless accompanied by this letter, which has been completed and signed by the Parent or Legal Guardian and delivered to the School Office. The School reserves the right to withdraw this service.