THE CASTLE SCHOOL MEDICATION DETAILS			
FULL NAME OF PUPIL		DATE	___/___/_____

Dear HeadTeacher

I request that my child be given the following medication.
Please complete one of the following (a) (b) or (c)

(A) DAILY MEDICATION UNTIL FURTHER NOTICE			
Name of Prescribed medication			
Dosage		Times during day	

(B) DAILY MEDICATION IN SPECIAL CIRCUMSTANCES			
Name of Prescribed medication			
Dosage		Times during day	
Circumstances in which the medication should be given :-			

(C) A SHORT COURSE OF MEDICATION			
Name of Prescribed medication			
Dosage		Times during day	
Date medication to start		Date medication to finish	

The above medication has been prescribed by the family doctor. It is clearly labelled indicating contents, dosage and child's name in FULL.

I accept that this is a service which the school is not obliged to undertake.

SIGNATURE		Parent/Guardian	(please indicate)	Date	____/_____/______
ADDRESS					

Note : Medication will not be accepted by the school unless this letter is completed and signed by the parent or legal guardian of the child and the administration of the medicine is agreed by the Head teacher.

The Governors and Head Teacher reserve the right to withdraw this service.