TORBAY

EDUCATION
SERVICES
DIRECTORATE

ED1S 94

ADMINISTRATION OF MEDICINES IN SCHOOLS

SACRED HEART RC PRIMARY SCHOOL

Name of pupil ....

Address ....
....
....
....

Medical condition of pupil ....

Name of prescribing doctor ....

Medicine ....

Dose .... Frequency of dose ....

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

Signed...
(Parent/guardian with parental responsibility)

I give permission for my son/daughter to carry their asthma inhaler with them whilst at school and to manage its use.

Signed...
(Parent/guardian with parental responsibility)