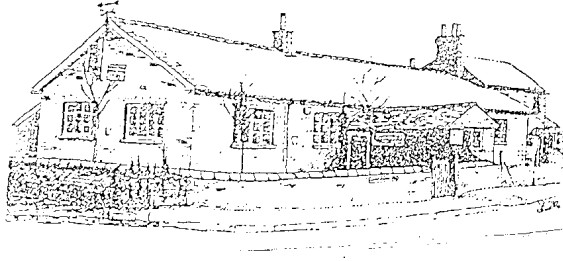


WORMEGAY CHURCH OF ENGLAND PRIMARY



MEDICATION AT SCHOOL REQUEST FORM

Name of child

Name of medication

How long is the course of medication?

Dose

Time of administration

Instructions for administration

Please give a telephone number where you can be contacted during the school day.

DECLARATION

I request that an member of school staff administers medication to my child as described above.

Signature _____

Name _____

Date _____