J H Godwin Primary School
Request for The School To Give Medication

Year Group .... DOB ....

I request that .... (Child's Name) be given the following:

EITHER Over The Counter Medication for .... (Condition)

☐ Paracetamol
☐ Sunscreen
☐ Ibuprofen
☐ Moisturising / Soothing preparations
☐ Antihistamines

Time of Last Medication		Duration of Course	
Dose Required		Time To Be Given	

OR The Medication Below has been prescribed by the doctor or hospital ☐

Name of Medication	
Duration of Course	
Dose Prescribed	
Time / Times To Be Given	
Side Effects	

Dosage taken:

Date	Dosage Given	Signed

Signed Parent Carer ....

Date ....

Medication will not be accepted by the school unless this form is completed and signed.
The Governors and Headteacher reserve the right to withdraw this service.

J H Godwin Primary School

Request for The School To Give Medication

Dosage:

Date	Dosage Given	Signed

Medication will not be accepted by the school unless this form is completed and signed.
The Governors and Headteacher reserve the right to withdraw this service.