

ADMINISTRATION OF MEDICINES IN SCHOOLS

Name of school - The Windsor Boys' 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 my permission for the Headteacher (or his/her nominee) to administer the medicine to my son/daughter during the time he/she is at school.

Signed _____

(Parent/Guardian/Person with parental responsibility)

Date

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

Signed _____

(Parent/Guardian/Person with parental responsibility)

Date

I give my permission for my teenage son/daughter to manage the use of his/her own pen injector for diabetes.

Signed _____

(Parent/Guardian/Person with parental responsibility)

Date
