Lytham CofE Primary School
TOGETHER WE GROW WITH GOD

REQUEST FOR SCHOOL TO ADMINISTER ASTHMA MEDICATION

Parents must complete this form if they wish the school to administer Asthma medication.

Please Note: The school will not give your child medicine unless you complete and sign this form. **The medicine must be prescribed by a doctor**, **be in the original container and must have the prescription label stating your child's name, dosage and expiry date.**

DETAILS OF PUPIL

Surname: _____ **Forename:** _____

Male / Female *(Delete as appropriate)* **D.O.B.:** _____ **Class:** _____

Address: _____

Condition: _____

DETALS OF MEDICATION

Name of Medicine	Date Prescribed	Duration of Treatment	Dosage and Method	Timing	Self-Administer Yes/No

Side effects from medication: _____

Emergency Procedures: _____

_____

CONTACT DETAILS

Name: _____ **Daytime Telephone Number:** _____

Address: _____

DECLARATION

I understand that I must deliver medicine personally to the School Office and accept that this is a service that school is not obliged to undertake.

Signed: _____ Parent/Guardian **Date:** _____

Relationship to child: _____