Headteacher
Diane Bate B.Ed (Hons) NPQH

Deputy Headteacher
Julie Clewes B.Ed (Hons)

Patterson Street
Newton-le-Willows
Merseyside
WA12 9PZ

Tel: 01744 678250
Fax: 01744 678251
E-mail: district@sthelens.org.uk

SHORT TERM MEDICATION

NAME OF PUPIL: ……

D.O.B: ……

DOCTOR ……

MEDICINE ……

DATE: ……

DURATION: ……

ANY OTHER INFO: ……

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INDEMNITY

I aware that the child named above needs to take the medication mentioned within school hours. I have provided the school with information about how the medication is to be administered and I undertake to ensure that the school has an adequate supply of the medication. I accept that as long as it is administered responsibly in accordance with the doctor's instructions, then I will not hold the school, nor the LEA, nor its servants or agents responsible in the event that the above named child suffers any adverse effect from the administration of the above mentioned medication.

Signed …….. Date ……
Parent/Carer

Signed …….. Date ……
Signature of First Aider who will administer medication

Signed …….. Date ……
Headteacher