



**REQUEST FOR THE ADMINISTRATION OF PRESCRIBED MEDICINE IN
SCHOOL**

I hereby request that should receive the following medication.

Name of medicine (as on container)

Dose of medicine

Time of administration

Expiry date if known

Duration of treatment

Signed parent/guardian Date

Mrs C Knowlson

Headteacher: Mrs C Knowlson
Wern Street, Cwmclydach, Tonypany, Rhondda Cynon Taff, CF40 2BQ
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