



St. Helens Metropolitan Borough Council

Name of School: **Billinge Chapel End Primary School**

Name of Pupil:

Date of Birth:

Name of Doctor/Consultant:

Medicine:

Prescribed By: Date:

Dosage: Duration:

Any other relevant information:

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Short Term Medication

Signed: Date:

Parent/Guardian

Long Term Medication

Signed: Date:

Parent/Guardian

INDEMNITY

I am aware that my child needs to take the medication mentioned above in school hours. I have provided the Head Teacher 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 Head Teacher, nor the L.E.A. nor its servants or agents responsible in the event that the above mentioned child suffers any adverse effect from the administration of the above mentioned medication.

Signed: Date:

Name of Person who will administer Medicine.

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