



ST. BARTHOLOMEW'S CHURCH OF ENGLAND SCHOOL

Commonfield, Wigginton, Herts. HP23 6EP

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I request and authorise that _____ (full name of child)

be given the following medication/cream

On the following day(s) and time(s) _____; Or, as required. Please list symptoms staff should be aware of for medication to be given:

Dose is _____ until _____ (date).

Please tick:

☐ I give permission for my child to have an asthma inhaler at school, and that my child can self-medicate as and when they feel it necessary.

☐ The medication has been prescribed to my child by _____ (name of practitioner), whom you may contact for verification. The medication is clearly labelled indicating the contents, dosage and the child's full name.

☐ I further authorise a member of staff to administer the medication/cream, as I am satisfied that he/she is competent in recognising the indications for its administration. If preferred, I also agree that my child can administer their own medicine, under the supervision of an adult.

☐ I confirm that I am the parent/person with parental responsibility in respect of the child and accordingly I am legally empowered to give authority for the administration of this medication.

☐ I accept that this is a service that the school is not obliged to undertake.

Signed _____ Date _____

Name _____



Co-Headteachers:
Mrs. Victoria Mowbray & Mrs. Kelly Wall

