

## Parental Request for the Administration of Medication during School Hours

| Child's Name:                                   | Class:   |
|---|--|
|   |  |
| I would like to request that my child be admini | istered medication as detailed on the attached |
| form with effect from                           | _ to   |
| I agree to abide by the school's policy on adm  | ninistering medication.                        |
| Thank you for your co-operation.                |  |
| Yours sincerely                                 |  |
|   |  |
| Parents Signature:                              | Date:  |

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