**ASTHMA MEDICATION**

**BRADWELL VILLAGE SCHOOL**

**REQUEST FOR THE ADMINISTRATION OF ASTHMA MEDICATION IN SCHOOL**

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| --- | --- |
| Child’s Name: ………………………….. | Class: ……………………………………….. |
| Doctor’s Name: ……………………….. | Doctor’s Tel No. ………………………… |

**The Doctor has prescribed the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Dosage Prescribed | Times to be taken | Expiry date of medication |
|  |  |  |  |
|  |  |  |  |

* The above medicine/inhaler must be clearly marked with the child’s name and delivered to the school personally
* The responsibility for advising the school of changes in dosage remains mine
* The school is under no obligation to administer medicines

I understand that whilst the school staff will endeavour to carry out these arrangements, no legal liability can be accepted by the School in the event of any failure to do so, or of any adverse reaction by my child to the administration of the drug.

Signed ……………………………………………………… (Parent/Guardian)

Date ………………………………………………………

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| --- | --- | --- |
| Date | Time | Staff Signature |
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