



Dear Parent

Your child .....

Requires more ..... to take in school.

The medicine is needed by .....

If there are any changes to the medication, please ensure that the chemist/pharmacy label is correct. School will need to see proof of any changes, such as a doctor's letter.

\_\_\_\_\_

### **CHANGE OF MEDICINE**

#### **Pupil details.**

Name. \_\_\_\_\_

DOB. \_\_\_\_\_

Address. \_\_\_\_\_

\_\_\_\_\_

#### **Directions for use.**

Name of medicine \_\_\_\_\_

\_\_\_\_\_

Route e.g. Oral, Gastrostomy \_\_\_\_\_

Dose \_\_\_\_\_ Time given \_\_\_\_\_

Special precautions \_\_\_\_\_

\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_