STRICTLY CONFIDENTIAL

Wiltshire Council
Where everybody matters

CONFIRMATION BY MEDICAL PRACTITIONER OF PRESCRIBED MEDICATION (FORM 3)

To be completed by a Medical Practitioner i.e. Family doctor, School Medical Officer, Consultant, etc.

To: ____

School/Centre: ____

Name of Child: ______________________________ Date of Birth: ______________

Address: ____

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I CONFIRM that I have prescribed medication which will need to be taken during school hours, for the above named child.

Name of Medication: ____

Length of time medication is required (give dates): ______________________________

Dosage: ____

Any special requirements (e.g. Timing, taken with meals, etc.): ______________________

____

Signature: ____

Date: ____

GP/Official Stamp: ____