HARINGEY COUNCIL

EDUCATION SERVICES

5.8.1.2 Annex 2: MEDICAL PRACTITIONER'S OF PRESCRIBED MEDICATION (form AOM 1A)

TO: **SCHOOL/CENTRE:**

To be completed by a Doctor/Family Doctor, School Medical Officer, Consultant etc.)

Name of child:	**DOB:**

Address:

....

....

....

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

TYPE OF MEDICATION:

....

....

LENGTH OF TIME MEDICATION IS REQUIRED (GIVE DATES):

....

DOSAGE:

....

ANY SPECIAL REQUIREMENTS (eg timing, taken with meals etc.):

....

....

....

GP/official stamp **Signed:** ....

Date: ....