PUPIL MEDICATION REQUEST

NOTE: Where possible the need for medicines to be administered at school should be avoided. Parents are therefore requested to try to arrange the timing of doses accordingly.

CHILD'S NAME: ____

PARENT'S SURNAME (if different) ____________________________

HOME ADDRESS ____

____

CONDITION OF ILLNESS_______________________________________

PARENTS HOME TEL NO______________________WORK_________________

MOBILE TEL NO______________________________________

GP NAME __________________________SURGERY___________________

TEL NO __________________________________

PLEASE TICK APPROPRIATE BOX

☐ My child will be responsible for the self administration of medicines as directed below

☐ I agree to members of staff administering medicines/providing treatment to my child as directed below

I agree to update information in writing about the child's medical needs held by the school

I will ensure that the medicines held by the school has not exceed its expiry date

MEDICINE NAME	DOSE	FREQUENCY/TIMES	COMPLETION DATE OF COURSE	EXPIRY DATE

Signed ___________________________________Parent/Guardian

Date ____________________________________