Pupil Medication Request

Child's Name_____ Class_____

Parent's Surname if different_____

Home Address_____

_____

Condition or Illness_____

Parent's contact phone number_____

GP Name_____ Location_____

Please tick the appropriate box:

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

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

☐ I agree to update information about my child's medical needs held by the school and that this information will be verified by a GP/Medical Consultant.

☐ I will ensure that the medicine held by the school has not exceeded its expiry date.

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.

Name of medicine	**Time of the last dose at home**	**Dose / Special Instructions**	**Frequency / Times**	**Completion date of course (if known)**	**Expiry date of medicine**

Allergies_____

Other Prescribed Medicines child takes at home_____

Signed_____**Date**_____

Parent's Name (Please Print)_____