PUPIL MEDICATION REQUEST & RECORD

CHILDS NAME……

DOB …….. CLASS……

Condition or Illness……..

Parent's surname (if different to child) ……

Home Address ……

……

Parent/Carer's contact No.……..

GP Name……

GP contact Number…….....

Name of medicine: ……

Dosage to be given: ……..

Time: ……

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 about the child's medical needs held by the school and that this information will be verified by GP and / or Medical Consultant

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

Signed _____(Parent/Carer) Date _____

Date	Time	Medicine given	Dose	Signature(s)