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PUPIL MEDICATION REQUEST

Pupil name: _____ Class _____ Date medicine provided by parent/guardian _____

Date of birth: _____

Parent/Guardian surname if different: _____

Home address: _____

Condition or Illness: _____

Parent/Guardian Home no: _____

Parent/Guardian Work no: _____ Parent/Guardian Mobile no: _____

GP Name: _____ Location & Name of Surgery: _____

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

□ with supervision □ without supervision

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

Name of medicine and date provided by parent/guardian	Dose	Frequency/times	Completion date of course if know	Expiry date

Special Instructions _____

Allergies _____

Other prescribed medicines pupil takes at home _____

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

I agree to update information about my 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 and agreed:

Parent/Guardian Signature: _____ Date: _____/_____/_____

Print Name: _____

School / Representative Agreement:

Staff Signature: _____ Date: _____/_____/_____

Print Name: _____ Job Title: _____