KNAPHILL FEDERATION OF SCHOOLS

APPENDIX 5

PUPIL MEDICATION REQUEST FOR PRESCRIBED AND NON-PRESCRIBED MEDICINE

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. The school will not give your child medicine unless you complete and sign this form.

Medicines must be in the original container as dispended by the pharmacy.

Pupil Name:		**D.O.B:**		**Class:**	
Parent's Surname if Different:		**Relationship to Child:**			
Home Address:					
Condition or Illness:					
Parent's Mobile Number:		**Work Number:**			
Doctor's Name:					
Surgery Name and Address (inc postcode)**:**					
Surgery Number:					

Please tick the appropriate box

☐ 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 and Strength of Medicine (as described on the container)	Quantity of Medicine Provided	Dose	Frequency/Time of Medicine	Completion Date of Course if Know	Expiry Date of Medicine
Special Instructions:					
Allergies / side effects the school needs to be aware of:					
Other Prescribed Medicines Child Takes at Home:					

The above information is, to the best of my knowledge, accurate at the time of writing. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

Parent /Guardian Signed and agreed:

Signature:		**Print Name:**	
Date Medication provided:			

School Representative Agreement:

Signature:		**Print Name:**	
Date Medication provided:			
Date Medication returned to Parent/Guardian:		**Quantity returned (if provided in tablet/sachet form):**	

PUPIL RECORD OF MEDICATION ADMINISTERED

Date	Time	Dose	Name of member of staff	Staff initials