

# PUPIL MEDICATION REQUEST

**Northmead Junior School**  
**Grange Road, Guildford, Surrey. GU2 9ZA**

Child's Name: \_\_\_\_\_

Parent's surname if different: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Condition or Illness: \_\_\_\_\_

☎ Parent's Home: \_\_\_\_\_

☎ Work: \_\_\_\_\_

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 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 \_\_\_\_\_ Date \_\_\_\_\_  
 (Parent / Guardian)

Name of medicine	Dose	Frequency / times	Completion date of course if known	Expiry date of medicine
Special instructions				
Allergies				
Other prescribed medicines child takes at home				

**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