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