PUPIL MEDICATION REQUEST: Hamsey Green Primary School, Tithepit Shaw Lane, Warlingham, Surrey, CR6 9AN

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)

| 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.

I have collected the above medicine: Date……

Name……Signature……

PUPIL MEDICATION RECORD

| Date | Time | Medicine given | Dose | Signature(s) |
|---|---|---|---|---|
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