Pupil Medication Request

Child's Name:-_____Class:_____

Parent/Carer's surname, if different:_____

Home Address:_____

Condition or Illness:_____

☎ Parent/Carer's Home:_____

☎ Work:_____ ☎ Mobile:_____

GP Name:_____ Location:_____ ☎_____

- Please administer medicines/provide treatment to my child as directed below.
- I agree to update the school with any changes to this request if necessary.
- I will ensure that the medicine held by the school has not exceeded its expiry date.
- I understand that I must deliver the medicine personally to Office Staff.

Signed_____ Date_____

Name of Medicine	Dose	Frequency/Times	Completion Date of Course (if known)
Special Instructions:			
Are there any side effects the school needs to be aware of?			

- **Please note: Only medicines prescribed by a doctor and provided in the original container as dispensed may be administered to pupils by school staff. The only exception to this is paracetamol.**