PUPIL MEDICATION REQUEST

School Name and Address: Meadowcroft Community Infant School, Little Green Lane, Chertsey KT16 9PT

Child's Name: _____

Parent's Name: _____

Home Address: _____

_____

Condition or Illness: _____

Parent's Home Tel: _____ Mobile: _____

GP Name:_____ Surgery:_____

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 _____

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:				

PUPIL MEDICATION RECORD

School Name and Address: Meadowcroft Community Infant School, Little Green Lane, Chertsey KT16 9PT

Child's Name: _____

Date	Name of Medicine	Dose	Time administered	Administered by