SHAWFIELD PRIMARY SCHOOL
PUPIL MEDICATION REQUEST

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.

Child's Name: _____
Parent's Name: _____
Home Address: _____
_____
_____
Home Telephone Number: _____
Work Telephone Number: _____
GP Name: _____Location_____Tel No._____
Condition or Illness: _____

☐ 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 it is my child's responsibility to come to the school office at the appointed time for medication.

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/carer)

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				

MEDICINES TAKEN

Name :…… Class ……
