Reigate School
Pendleton Road
Reigate
Surrey RH2 7NT

STUDENT MEDICATION REQUEST

Student's Name ……

Parent's Surname if different ……..

Home Address ……

……

……

Condition or Illness ……

☏ **Parent's Home ……** ☏ **Work ……...**

G.P. Name …… ☏ **……..**

Please tick the appropriate box

☐ My child will be responsible for self-administration of medicines as directed below.

☐ I agree to members of staff administering medicines/providing treatment to my child as directed below.

I do/do not need Student Services Staff to call me for verbal permission before administering medicines/providing treatment to my child.

I agree to update information about the child's medical needs held by the school.

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:				