STUDENT MEDICATION REQUEST

Child's Name: ………………………………………………………………………….

Parent/ Carer's Name: ……………………………………………………………

Parent/ Carer's Telephone Number: ………………………………………….

G.P. Name: ………………………………**Telephone number…**…………………………………………….

MEDICINE

Name of Medicine	Dose to be Taken	Frequency per Day	Completion Date of Course (if known)	Expiry Date of Medicine
Special Instructions:				
Allergies:				
Other Prescribed Medicines Child Takes at Home:				

Please delete the inappropriate statement

My child will be responsible for self-administration of medicines as directed above.	**N / Y**
I agree to members of staff administering medicines/providing treatment to my child as directed above	**N / Y**

I do/ do not need Student Services staff to call me for verbal permission before administering medicines/ providing treatment to my child (please delete as appropriate).

I agree to keep the school updated on my child's medical needs.

I will ensure that any medicines held by the school for my child has not exceeded their expiry date.

Signed: …………………………………………………………**Date**: ………………………
(Parent/ Carer)