Reigate School

GREENSAND

STUDENT MEDICATION REQUEST

Child's Name: …….

Parent/ Carer's Name: ……..

Home Address: ……..

…….

Parent/ Carer's Telephone Number: …….

G.P. Name: ……..

G.P. 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 tick the appropriate box

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

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

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)