Mauldeth Road Primary School

PUPIL MEDICATION REQUEST

Child's Name: ______________________________ Class: ____________

Parent/Carers Name: ____

Home Address: ____

____

Condition or Illness: ____

Parent/Carers Telephone: _______________________

Parent/Carers Work Telephone: ___________________

GP Name: _____________________ Location:______________________

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 my child knows that they must report to the office at the agreed time and that staff will not be expected to go and find them.

I will ensure that the medicine held by the school has not exceeded its expiry date and will collect any medicines from school at the end of each half term

Signed: ____________________________________ (Parent/Carer)

Date: __________________________