

ST LAWRENCE C OF E (AIDED) PRIMARY SCHOOL

PUPIL MEDICATION REQUEST

Child's Name: _____ Class: _____

Condition or Illness: _____

Parent's Home Tel.: _____ Work Tel.: _____

GP Name: _____ Telephone No.: _____

Please tick the appropriate box

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

I agree to update information about my child's medical needs held by the school and that this information will be verified by the GP and/or Medical Consultant.

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 medicine child takes at home:				

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.