CURRY MALLET Church of England VC PRIMARY SCHOOL

PUPIL MEDICATION REQUEST

Child's Name …… Class ……

Condition or Illness ……

GP Name: …… GP Tel. 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 agreed to update the School as appropriate with information about my child's medical needs 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 and that asthma inhalers are not empty.

I will collect medicines from the School office at the end of the day/term as appropriate and understand that any medicines which have failed to be collected at the end of term will be destroyed by the School.

Signed …… Date ……
[Parent]

Name of Medicine	Dose	Frequency/Time to be administered	Completion Date of Course (if known_	Expiry Date of Medicine (if known)
Special Instructions:				
Allergies:				
Any Other Medicines 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.