CLAYGATE PRIMARY SCHOOL

Pupil Medication Request

Note: where possible the need for medicines to be administered at school should be avoided. Parents are therefore requested to arrange the timing of doses accordingly.

Child's name:	
Parent's name:	
Home address:	
Contact telephone (home):	
Contact telephone (work / mobile):	
Condition or illness for which medication below is prescribed:	

Name of medicine	Dose	Frequency / times	Completion date of course	Expiry date of medicine
Special instructions:				
Allergies:				
Other prescribed medication taken by the child at home				

Please tick the appropriate box:

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

I agree to members of staff administering medicines as above ☐

I agree to update the information about my 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 the medicine held by the school has not exceeded its expiry date.

Signed …… (parent) Date ……..

Date	Time	Medication	Dose	Staff Member