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 ……..

Signed …… (Headteacher) Date ……..

Date	Time	Medication	Dose	Staff Member