TOMLINSCOTE SCHOOL

STUDENT MEDICATION REQUEST

Student Name: _____

Condition or Illness: _____

Parents/Carers surname if different: _____

Home Address: _____

Contact Number: _____

GP name, Practice and telephone number: _____

_____

Please tick appropriate box:

☐ My Child will be responsible for self-administration of medicines as directed below.

☐ I agree to members of staff administrating medicines/providing treatment to my child as directed below.

Name of medicine	**Dose**	**Frequency/times**	**Expiry date of medicine**
Special instructions			

NOTE: Where possible the need for medicines to be administered at school should be avoided. Parents/Carers are therefore requested to try and arrange the timing of doses accordingly.

All medicines must come in the original packaging.

Agreed and Signed:

☐ I agree to update 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.

Parent/Carer Signature: _____ Date: _____

Print Name: _____