

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
Name of medicine	Dose	rrequency/ times	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:			