**TOMLINSCOTE SCHOOL**

STUDENT MEDICATION REQUEST

Student Name: _____

Parent's surname if different: _____

Home Address: _____

Condition or Illness: _____

☎ Parent's Home Number: _____

☎Parent's Work Number: _____

GP Name: _____Location: _____ ☎ _____

**Please tick appropriate box:**

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

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

| **Name of Medicine** | **Dose** | **Frequency/times** | **Completion date of course if known** | **Expiry date of medicine** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| Special Instructions: | | | | |
| Allergies: | | | | |
| Other prescribed medicine child takes at home: | | | | |

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

**All medication 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 exceed its expiry date.

**Parent / Guardian Signature: _____ Date: ____/ ____/ ____**

**Print Name: _____**