Pupil Medication Request Form for Polesden Lacey Infant School, Oakdene Close, Off Howard Road, Great Bookham Surrey KT23 4PT

Child's Name: …….. Parent's surname if different: ……

Home Address: ……..….

Condition or Illness: ..……...…….

Parent's Home Telephone No: ……..…… Work: ……..…….

G. P Name and Location: …… Tel. No: ……..……..

Please tick appropriate box

- ☐ My child will be responsible for the self-administration of medicines as directed below with supervision.
- ☐ 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)	Expire date of medicine
Special Instructions:				
Allergies:				
Other prescribed medicines 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 to arrange the timing of doses accordingly.

I agree to update information about my child's medical needs held at school and that this information will be verified by GP and/or Medical Consultant.

I will ensure that the medicine held at school has not exceeded its expiry date.

Signed and agreed:

Signed: ……..……..… Date: ……
Parent/Guardian

Print Name: ……

School/Setting Representative Agreement:

Signed: ……..……..… Date: ……

Print Name: ……..… Job Title: ……..

Pupil Medication Record for Polesden Lacey Infant School

Child's Name: …… Child's Class: …….

Date Medicine Provided by Parent: ……

Quantity Received: …….

Name and Strength of Medicine Received: ……..

Expiry Date: …….. Dose and Frequency of Medicine: ……..

Quantity and Date Returned to Parent: ……

Staff Signature: ……

Parent Signature: …….

DATE GIVEN	TIME GIVEN	NAME OF MEDICINE GIVEN	DOSE GIVEN	STAFF SIGNATURE	NAME OF STAFF MEMBER