Pupil Medication Request

Child's Name ……..

Condition or illness……

Please tick the appropriate boxes:

- ☐ My child will be responsible for the self-administration of medicine as directed below
- ☐ I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of an emergency, as staff consider necessary.
- ☐ I will ensure that my child is made aware that staff have permission to give this medication and that they must ask for it if they are concerned that a dose has been missed.

Signed……date…….
Parent/guardian

Name of medicine	Dose	Frequency/times	Completion dates of course	Expiry date of medicine

Any additional information / notes:

Staff to complete reverse when giving medication

Pupil Medication Record

Child's Name:				Date of Birth:	
	Date	Time	Medicine Given & dosage	Signature Child	Signature staff
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					