APPENDIX 3
PUPIL MEDICATION REQUEST
St Thomas' CE (VC) Junior School, Featherstone, West Yorkshire, WF7 5BG.

Child's Name: _____

Parent's surname if different: _____

Home Address: _____

_____

Condition or Illness: _____

✈ Parent's Home: _____

✈ Work: _____

GP Name:_____Location:_____✈ _____

Please tick the appropriate box
✈ My child will be responsible for the self-administration of medicines as directed below.
✈ I agree to members of staff administering medicines/providing treatment to my child as directed below.
I agree to update information about the 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. Signed

_____Date _____

Name of Medicine	Dose	Frequency/ Times	Completion date of course	Expiry date of Medicine
Special Instructions				
Allergies				
Other prescribed medicines taken at home				

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