ANNEX D:

PUPIL MEDICATION REQUEST

School Name & Address:
St Dunstan's Catholic Primary School, Onslow Crescent, Woking, Surrey, GU22 7AX

Child/young person's Name: ………………………………..…..……

Class:……..……………………

Parent / Carer's surname if different: ………………..…………………………..………

Home Address: ……………………………………………………..………………..……...

……………………………………………………………………………..……………………..

Condition or Illness: ……………………..…..………………..………………………...

☎ Parent / Carer'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.

☐ With supervision ☐ Without supervision

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

☐ I give permission in an emergency for the school to administer their emergency adrenaline auto-injectors.

Signed: ………………………………………………… Date: ……………………….
Parent / Carer

Name of Medication	Dose	Frequency/times	Completion date of course if known	Expiry date of medicine.
Special instructions:				
Allergies:				
Other prescribed medicines child/young person takes 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.

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.

PLEASE ENSURE YOU PROVIDE THE CORRECT SYRINGE OR MEASURING SPOON WITH ANY MEDICATION.

Parent / Carer

Signature: …………………………………………………………… Date: ……………………

Print Name: …………………………………………………………

School / Setting Representative Agreement:

Signature: …………………………………………………………… Date: ……………………

Print Name: …………………………………………………………

Position: ………………………………………………………………

PUPIL MEDICATION RECORD

Child's Name: ……………………………..…………………....……

Date of Birth: ……………………………………….

	Date	Time	Medicine Given	Dose	Signature
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					