SOUTH CAMBERLEY SCHOOL **MEDICATION REQUEST**

Campus/Class			
Child's Name			
Parent's Name			
Home Address			
Condition/Illness			
Parent's Home No.			
Parent's Work No.			
Doctor's Name & Address		Tel. No.	

Please tick as appropriate:

☐ 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

Name of Medicine	Dose	Frequency/Times	Date Course finished	Expiry date of medicine	Quantity supplied

Special Instructions:	Allergies:	Other prescribed medicines child takes at home:

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

School staff administer medicines voluntarily. If staff have difficulty administering the medicine for your child then we will call the person named on this form for them to try.

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

I will ensure that the medicine held by the campus has not exceeded its expiry date and understand that any medication held in the office will be sent home at the end of each term.

Signed and Agreed: Signature:……Date: ……..

Print Name:……..

PUPIL MEDICATION RECORD

Child's Name: …… Date of Birth: ……..

Date	Time	Medicine given	Dose	Quantity left	Signature

Administration of medicines check		
Date:	Checker:	Comments:

Date:	Checker:	Comments: