PUPIL MEDICATION REQUEST

Windlesham Village Infant School, School Road, Windlesham, GU20 6PB

Contact Details

Child's name:			
Parent / carers name:			
Home address:			
Phone no (primary):		Phone no (secondary):	
GP name:		Surgery:	

Medication Details

Condition:			
Medication required?	Yes / No		
If yes, please state:	Name of medication		
	Dosage required		
	Frequency of administration		
Does the school need to store medication?	Yes / No	Does the medication need to be refrigerated?	Yes / No
Please tick the appropriate box:	My child will be responsible for the self-administration of the medicine listed above **OR**		
	I agree to members of staff administering medicines / providing treatment to my child as directed above		
Parent / carer contact required **prior** to administering medicine?	Yes / No	Parent / carer contact required **after** administering medicine?	Yes / No
Allergies:			
Other prescribed medicines child takes at home:			
Any special instructions?			

Please continue overleaf

Internal use only. Medication stored in: Classroom ☐ Office ☐ Both ☐

Declaration and signature

I agree to update information about the child's medical needs held by the school and that this information may be verified by the GP and/or medical consultant.

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

Signed: _____ Date: _____

(Parent / Carer)