Mauldeth Road Primary School

PUPIL MEDICATION REQUEST

Child's Name	Class
Condition or illness	
Medication	
Instructions for use	
Parent's Name	
Home Address	
Parent's telephone number Home	
Mobile	
GP Name	
GP Address	

I agree to update the information about my child's medical needs and that this information will be verified by the GP or Consultant as required

I will ensure that the medication held by the school is in date and will collect any medicines from school at the end of each half term

Please tick as appropriate

- ☐ I agree to members of staff administering medications/treatment to my child as directed
- ☐ My child will be responsible for the self-administration of medication as described
- ☐ I will ensure that my child reports to the office at the correct time

Signed .... Date..

Mauldeth Road Primary School

Child's name..

Date	Time	Medication	Dose	Reaction noted?	Signature