Buckland Primary School
Berryscroft Road
Laleham, Staines
Middlesex TW18 1NB

PUPIL MEDICATION REQUEST

Child's Name _____

Parent's Surname (if different) _____

Home Address _____

_____

Condition or Illness _____

Parent's Home Tel No: _____ Parent's Mobile Tel No: _____

Parent's Work Tel No: _____

GP Name _____ Location _____ Tel No: _____

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 teatment 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 _____
(Parent)

NAME OF MEDICINE	DOSE	FREQUENCY/ TIMES	COMPLETION DATE OF COURSE IF KNOWN	EXPIRY DATE OF MEDICINE

Special Instructions:

Allergies:

Other prescribed medicines child 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.

SURREY
COUNTY COUNCIL