CHILD MEDICATION REQUEST

PLEASE PRINT & USE BLACK OR BLUE PEN

PRIVATE & CONFIDENTIAL

Child's Name:		Date of Birth:	Child's class:
Parent's surname if different:		Home telephone:	
Home address:			
Emergency contact numbers: numbers and names of contacts:	1.	2.	3.
Doctor's Name:			
Doctor's Address & phone number			
Nature of condition or illness			

• I agree to members of staff administering medicines/providing treatment or care to my child as directed below. • I will ensure that the medicine held by the school has not exceeded its expiry date.	Parent/ legal guardian with parental responsibilities Name in print: Date:
	Signed:

Name of medicine	Dose & instrument for administering dose	Frequency/ Times	Completion date of course of medicines if known	Expiry date of medicine

Special instructions/medicines taken at home/ allergies	