PUPIL MEDICATION REQUEST

SCHOOL: Meath Green Infant School, Kiln Lane, Horley

CHILD'S NAME _____

CLASS _____

Parent's surname if different: _____

Home Address: _____

_____

Condition or Illness: _____ _____

Parent's Home ☎ _____ **Work ☎** _____

Doctor's Name _____**Surgery** _____ **☎** _____

I agree to members of staff administering medicines/providing treatment to my child as directed below.
I agree to update information about the child's medical needs held by the school.
I will ensure that the medicine held by the school has not exceeded its expiry date.

Signed _____ **Date** _____
(Parent)

Name of Medicine	
Dosage	
Frequency/Times	
Special Instructions:	
Storage requirements (eg room temperature/fridge):	
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.