NEW HAW JUNIOR SCHOOL

PUPIL MEDICATION REQUEST

Child's Name……..Date of birth ……..Class…….
Parent's Name……
Address……
……..
Condition or Illness:……..
Parent's Contact number:…….....
GP Name & Address:……
GP Telephone No…….

Please tick the appropriate box:

☐ My child will be responsible for the self-administration of medicines as directed below:

☐With supervision ☐ Without supervision

☐ 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 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.

Name & Strength of Medicine	Dose	Frequency/Time	Completion date if necessary	Expiry Date

If administering paracetemol, please state at which time your child had their last dose.....

Please note: Parents are responsible for collection and disposal of unused medicines.

Special Instructions:……
Allergies:……
Other prescribed medicine your 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.

Signed……(Parent) Date……

Signed……(Child) Date……

New Haw Junior School Agreement

Signature…… Date……

Print Name…..

Date	Quantity Rec'd	Staff signature	Quantity Ret'd	Date Returned	Staff signature

Pupil Medication Record

Date	Time	Medicine Given	Dose	Staff Name/Initials