Pupil Medication Request Form

Child's Name: ..... Class: .....

Parent Contact Number: .....

Name of medicine: ..... Dosage: .....

Time that Medicine should be administered: .....

Dates that medicine should be administered:

From: ..... To: ..... Total number of days: .....

Is your child likely to experience any side effects whilst taking this medicine?

YES ☐ NO ☐

If yes, please provide further details:

.....

.....

Does medicine need to be given to After School Club at the end of the day?

YES ☐ NO ☐

I request that a member of staff administers medicine to my child and will contact the school at the time at which this medicine is due to be administered. However, if for any reason the medicine fails to be administered, I understand that the school cannot be held responsible.

I will ensure that the medicine held by the school has not exceeded its expiry date.

I have read the school's Medicine Policy.

PARENT SIGNATURE: ..... **DATE:** .....

TO BE COMPLETED BY STAFF MEMBER GIVING MEDICINE:

Date & Time Given	Dosage	Signature
