Student Medication Request

St Peter's Catholic School
Horseshoe Lane East
Guildford
GU1 2TN

Student's Name _____

DOB _____

Parent/Carer's surname if different _____

Home Address _____

_____

Condition or Illness _____

☎ Parent/Carer's Home _____

☎ Work _____

☎ Mobile _____

GP Name _____Practice _____ ☎_____

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.

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 the school should be avoided. Parents/Carers are therefore requested to try to arrange the timing of doses accordingly.

I agree to update information about my child's medical needs held by the setting and that this information will be verified by GP and/or medical Consultant.

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

Signed and agreed:

Child/Young Person

Signature _____ Date _____

Print Name _____

Parent/Carer

Signature _____ Date _____

Print Name _____

School Representative Agreement:

Signature _____ Date _____

Print Name _____

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