

PUPIL MEDICATION REQUEST



School Name and Address: **Hinchley Wood Primary School**
 Claygate Lane
 Esher
 Surrey – KT10 0AQ

Child's name: _____

Class: _____

Parent's surname if different: _____

Condition or illness: _____

Parent's telephone numbers:

Home: _____ Work: _____ Mobile: _____

Please tick the appropriate boxes:

- I agree to members of staff administering medicines/providing treatment to my child as directed below.
- I have provided a spoon/syringe for this
- 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	Dose	Frequency/times	Completion date of course if known	Expiry date of medicine
Special Instructions:				
Allergies:				
Other prescribed medicines Child takes at home:				