Lingfield Primary School
Pupil Medication Request

Child's Name: _____ DOB: _____

Parent's surname if different: _____

Home address: _____

_____

 Parent's home: _____  Parent's work: _____

GP Name: _____ Location: _____  _____

Please tick the appropriate box:

☐ My child will be responsible for the self-administration of medicines as directed below.
☐ I agree to members of staff administering medicines/providing treatment to my child as directed below.

I agree to update information about my 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.

Signed: _____ Date: _____
(parent)

Condition or Illness	
Symptoms	
When the medication should be administered, i.e. times/when certain symptoms appear	
Medication	
Dose	
How long medication required/completion date of course	
Expiry date of medication	
Medication administered at home	
Allergies	
Special instructions	

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.