PLEASE COMPLETE IF RELEVANT AND RETURN TO THE SCHOOL OFFICE

CHILD / YOUNG PERSON MEDICATION REQUEST

Setting name and address: _____

_____

Child / young person's name: _____

Parent's surname if different: _____

Home address: _____

_____

Condition or Illness: _____

☎ Parent's Home no: _____

☎ Parent's Work no: _____

GP Name:_____ Location:_____ ☎ _____

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 / young person takes at home:				

Trumps Green Infant School is committed to safeguarding, child protection and promoting the welfare of children and young people. We expect all members of the school community including staff, parents, carers, volunteers and governors to demonstrably share this commitment.

Child/ Young Person Medical Request Cont'd…

NOTE: Where possible the need for medicines to be administered at the setting should be avoided. Parents/Guardians 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 / Guardian

Signature: _____ Date: ____/____/____

Print Name: _____

School / Setting Representative Agreement:

Signature: _____ Date: ____/____/____

Print Name: _____ Job Title _____

Ref. Supporting Pupils with Medical Conditions Surrey Guidance January 2016