Ottershaw Christ Church C of E Infant and Junior Schools
www.ottershawcofeschools.surrey.sch.uk

PUPIL MEDICATION REQUEST

Child's Name: _____

Parent's surname if different: _____

Home Address: _____

_____

Condition or Illness: _____

☎ Parent's Home: _____ ☎ Mobile: _____

GP Name: _____ Practice: _____

☎ GP: _____

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)

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