ST. PAUL'S CATHOLIC PRIMARY SCHOOL
PUPIL MEDICATION REQUEST

PLEASE USE CAPITALS

Child's Name: ……...

Year: …… Class: ……

Details of Condition or Illness:
……
……

Parents' Home Tel. No.: ……
Parents' Work Tel. No.: ……

Name of G.P. who prescribed medication: ……
Address: ……..
Tel. No.: ……

Date of last Tetanus: ……

Name of Medicine	Dose	Frequency and times required	Completion Date of course	Expiry Date of Medicine

I agree to members of staff administering the measured dose requested of the aforementioned medicine to my child.

Signed (*Parent/Guardian*): ……...

Name in capitals please: ……..

Date: ……..

Please note that Surrey County Council Guidelines state that:

1. Medicines should be provided in the original containers with a spoon or syringe for use by the office.

2. Medication containing Ibuprofen can only be administered if prescribed.

Nb. Where possible, the need for prescribed medicines, to be administered at school, should be avoided. Parents are therefore requested to try to arrange the timing of doses accordingly.

AS WITH ALL MEDICATION HELD IN SCHOOL IT IS THE PARENTS' RESPONSIBILITY TO CHECK THE EXPIRY DATE AND AVAILABILITY OF THEIR CHILD'S MEDICATION.