PUPIL MEDICATION REQUEST

School Name and Address: **Milford School, Church Road, Milford, GU8 5JA**

Child's Name: **……**

Condition or Illness: **……**

Parent's Home Tel. No.: **…….. Work ……....**

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 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.

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.

Signed …… Date ……...
(Parent)