Westfield Primary School PUPIL MEDICATION REQUEST

Child's Name: _____

Parent's Surname if different: _____

Home Address: _____

Condition or Illness: _____

Parent's home telephone number: _____Work/Mobile:_____

G.P. Name:_____Location:_____Telephone:_____

Please tick the appropriate statement:

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 the expiry date.

I agree to notify the class teacher of my child's need for medication and timings; and to telephone the school office each day to confirm the administration of my child's medication.

The above information is, to the best of my knowledge, accurate at the time of writing. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signed:_____Date:_____

Name of Medicine	Dose	Frequency/Time	Completion date of course (if known)	Expiry date of medicine
Special Instructions:				
Allergies:				

NOTE: Where possible the need for medicines to be administered at school should be avoided. Parents are therefore requested to try to arrange timings of doses accordingly.

Westfield Primary School PUPIL MEDICATION RECORD

Child's Name: _____ Date of Birth: _____

	Date	Time	Medicine Given	Dose	Signature
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					