

# BUSBRIDGE INFANT SCHOOL

## PUPIL MEDICATION REQUEST

Child's Name: ..... Class .....

Condition or illness: .....

☎ Parents/Guardian's Home: ..... ☎ Work: .....

G.P: ..... ☎ .....

### Please tick the appropriate box:

- This will be required only on the following date(s): .....
- This will be required on a long term basis.
- 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 or in the case of an emergency, as staff consider necessary.

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.

Signed ..... Date .....  
(Parent/Guardian)

Name of Medicine	Dose	Frequency/times	Completion date of course, if known	Expiry date of medicine
Special Instruction				
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.**