PUPIL MEDICATION REQUEST

PLEASE COMPLETE THIS FORM IF YOU WOULD LIKE HOLY TRINITY STAFF TO ADMINISTER MEDICINE TO YOUR CHILD

CHILD'S NAME: .... **YEAR/CLASS:** ……..............

CONDITION OR ILLNESS: ....

Please note that only prescribed medicines will be administered by the school. Non-prescription medicines, such as Calpol, cough medicine, Ibuprofen, Piriton and throat lozenges will not be given.

1) I have discussed the prescribed medicine, specified below, with my GP and they have advised that it must be administered in school hours.

☐ **If this box is not ticked, we cannot administer the medicine.**

Please delete one of the statements below, as appropriate*

* My child will be responsible for self-administration of medicines, as directed below.

* I agree to members of staff administering medicines and providing treatment to my child as directed below, or, in the case of an emergency, as staff consider necessary.

SIGNED: .... **DATE:** ……….......................
(Parent/Guardian)

Parents/Guardians are responsible for checking that medication is within date and is clearly labelled with their child's name and year/class.

Name of Medicine	Dose	Frequency/ Times	End Date	Date Given	Time	Signature
(To be completed by Parent/Guardian)				(To be completed by School Office)		

For further information, please refer to our 'Medication Policy', which is available on our website, or from the School Office.

Name of Medicine	Dose	Frequency/ Times	End Date	Date Given	Time	Signature
(To be completed by Parent/Guardian)				(To be completed by School Office)		