Holy Family Catholic Primary School

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PUPIL MEDICATION REQUEST

Pupil's Name	
Date of Birth	
Year Group	
Condition or Illness	

Name of Medicine	
Expiry of Medicine	
Dose & Frequency/Times	
Special precautions / other Instructions	
Are there any side effects that the school needs to know about?	
Self-administration	Yes / No

NB: Medicines must be in the original container as dispensed by the pharmacy

Parent / Carer's Name	
Daytime Contact Number	
Relationship to child	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. 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.

Parent's Signature: ……………………………………………………………………….…………………… Date: ………………………………….

Staff signature: ………………………………………………………………………………………… **Date: ………………………………….**