**REQUEST FOR ADMINISTRATION OF MEDICATION / TREATMENT**

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| --- | --- | --- | --- | --- |
| Pupil Name |  | | Year Group |  |
| Parent Contact Numbers |  | | | |
| GP Name & Phone number |  | | | |
| Please tick below as appropriate: | | | | |
| My child will be responsible for self-administration of medication detailed below | | | |  |
| I agree to a member of staff administering medication / providing treatment to my child as detailed below or in the case of an emergency as staff consider necessary. | | | |  |
| Medication | Dose | Times / Frequency | Completion date of course | Expiry Date of medication |
|  |  |  |  |  |
|  |  |  |  |  |
| Special Instructions |  | | | |
| Allergies |  | | | |
| Other prescribed medication my child is taking at home |  | | | |
| ALL MEDICATION IS TO BE HANDED TO THE STAFF IN THE OFFICE FOR SAFE KEEPING. | | | | |
| Signed: |  | | Date |  |