CHILD MEDICATION REQUEST

Setting name and address:	**St Joseph's Catholic School Epsom**
Child/young person's name	
Parent's surname if different:	
Home address	
Parent's Home no	
Parent's Work no:	
GP Name	
Location	

	Please tick to indicate that you agree to members of staff administering medicines /providing treatment to my child as directed below.

Condition or Illness:	

Name of medicine	Dose	Frequency/times	Completion date of course if known	Expiry date of medicine
Special Instructions:				
Allergies:				
Other prescribed medicines child/ young person takes at home:				

NOTE: Where possible the need for medicines to be administered at the setting should be avoided. Parents/Guardians are therefore requested to try to arrange the timing of doses accordingly. I agree to update information about my child's medical needs held by the setting and that this information will be verified by GP and/or medical Consultant. I will ensure that the medicine held by the setting has not exceeded its expiry date.

Signed and agreed:

Signature: _____ *Parent / Carer* Date: ____/____/____ Print Name: _____

School / Setting Representative Agreement:

Signature: _____ Date: ____/____/____ Print Name: _____