HIGHFIELD SOUTH FARNHAM
WEYDON LANE FARNHAM SURREY GU9 8QH
Headteacher: Mr Gregory West
Telephone 01252 721079 Fax 01252 734870

MEDICATION REQUEST

Name of Child:_____

Parent's name: _____

Home address:_____

Condition or Illness: _____

Parent's Phone no:_____

Parent's Work no: _____

GP Name:_____ Location:_____

Please tick the appropriate box

☐ My child will be responsible for the self-administration of medicines as directed below.

☐ With supervision ☐ Without supervision

☐ I agree to members of staff administering medicines/providing treatment to my child as directed below.

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.

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Signed and agreed:

Child / Young Person

Signature: _____

Print Name= ----------

Date:_____/_____/_____

Parent / Guardian

Signature: _____

Print Name: ----------

Date:_____/_____/_____

School / Setting Representative Agreement:

Signature: _____

Print Name: _____

Job Title _____

Date:_____/_____/_

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