CHILD'S MEDICATION REQUEST

Child's name:_____Class_____

Condition or illness: _____

☎Parent's/Guardian's Home Number _____

☎Parent's/Guardian's Work Number _____

(***Please ensure that we are able to contact you at all times)***

GP Name: _____☎_____

Location: _____

All medication must have the pharmacy label on stating the child's name and dosage.

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

Name of prescribed medicine *	Dose	Frequency/times	Completion date of course if known	Expiry date of medicine
Special instructions:				
Allergies:				
Other prescribed*medicines taken at home				

*As prescribed by a doctor, dentist, nurse or pharmacist.
Medicines containing aspirin will only be given if prescribed by a doctor.

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 will ensure that the medicine held by the setting has not exceeded its expiry date.

Signed and Agreed:
Parent/Guardian
Signature _____ Date _____
Print Name _____