

Forest Park School
Pupil Medication Request

Child's Name:

Parents Home Telephone Number

G.P. Name and address:

Telephone Number

Does your child have and current medical condition or illness? YES NO

Please give details.....

Please tick the appropriate box

- My child will be responsible for the self administration of medicines as directed below.
- I agree to members of staff administering medicines/providing treatment to my child as directed below
- I agree to update information about the child's medical needs held by the school
- I will ensure that the medicine held by the school has not exceeded its expiry date.

Name of medicine	Dose	Frequency/times	Completion date of course if known	Expiry date of medicine

Special instructions

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Does your child have any allergies: YES NO

Details.....

Signed..... Date.....

Note: Where possible the need for medicines to be administered at school should be avoided. Parents are therefore requested to try to arrange the timing of doses accordingly.