CHILD'S MEDICATION REQUEST

Northmead Junior School

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: _____ GP Tel: _____

Location: _____

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

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 agree to members of staff administering medicine/providing treatment to my child as directed above. 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: _____