PUPIL MEDICATION REQUEST – to be held in School Office

Kingswood Primary School - Buckland Road, Lower Kingswood, Surrey, KT20 7EA

Child's Name: …… Date of Birth: ……

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

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.*

- I am aware that the school cannot guarantee to always give the stated dosage at the set time, although will endeavour to do so and cannot, in any way, be held responsible for the administration of medicines.
- I understand that if permission is granted, I will not hold the school responsible for any liability towards my child in the above matter.
- I agree to update information about my child's needs and will ensure that the medicine held by the school has not exceeded its expiry date.
- I agree to a member of staff to administer/supervise the medication as above.

Parent/Guardian

Signature ……..…….. Date …….

Print Name …… Telephone No. ……..

PUPIL MEDICATION RECORD

Child's name: _____ Date of Birth: _____

	Date	Time	Medicine Given	Dose	Signature(s)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
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