



MEDICATION REQUEST FORM

The school staff will not give your child any medication unless you complete and sign this form

STUDENT NAME:

DATE OF BIRTH: NHS NUMBER:

ADDRESS:

TEL:

ALLERGIES:

Medication & strength	Time	Dose	Full directions for use

I understand that I must inform the transport escort that medicines are being transported to school.

I consent to the school nursing staff or school staff giving the above medication to my child

Name: Date:

Signature:

Relationship to pupil: