PUPIL MEDICATION CONSENT FORM
(Occasional/long term prescribed medication)

Dovers Green School
Rushetts Road
Reigate
Surrey
RH2 7RF

Child's Name: _____ Class: _____

Parent's Name: _____

Home Address: _____

_____

Parent's Telephone Number: _____

Condition or Illness: _____

GPs Name: _____

Address: _____

Telephone Number: _____

I agree to members of staff administrating medicines/providing treatment to my child as directed overleaf.

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.

I agree to collect the medicine at the end of the day, or at the end of the course of antibiotics, and understand that if I do not, the medicine will be disposed of.

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.

Signed (Parent): _____ Date: _____

Name of Medicine	Dose	Frequency/Times	Completion Date	Expiry Date

Special Instructions: