BUSHY HILL JUNIOR SCHOOL

PUPIL MEDICATION REQUEST

Child's Name: ……..

Address:……

……

……

Parent's home telephone number:……

Parent's work telephone number: ……

Condition or Illness: ……

G.P: …….. Telephone: ……

I have read the school's Policy for the Administration of Medicines and I give permission for my child to be given medicines as directed below.

Please delete as appropriate:

My child has previously been administered this medicine and suffered no adverse reactions. YES / NO*

*If you have answered NO, please note that the school can take no responsibility in the event of your child suffering an adverse reaction to the medication being administered by the school staff.

Signed …… Date: ……

Parent / Guardian

Name of Medicine	Dose	Frequency