COOMBE

preparing you for a world of opportunity

STUDENT MEDICATION REQUEST

Student's name: _____ Tutor Group: _____

Parent/Carer's surname if different: _____

Home Address: _____

_____

Condition or illness: _____

Parent/Carer's telephone numbers:

Home: _____ Work: _____ Mobile: _____

G.P. Name: _____ G.P. Telephone: _____

G.P. Address: _____

Please tick the appropriate boxes:

☐ I agree to members of staff administering medicines to my son/daughter as directed below.

☐ I agree to update information about my son/daughter's medical needs held by the school.

☐ I will ensure that the medicine held by the school has not exceeded its expiry date.

Signed: _____ Dated: _____

(Parent/Carer)

Name of Medicine	Dose	Frequency/times	Completion date of course if known	Expiry date of medicine
Special Instructions:				
Allergies:				
Other prescribed medicines your son/daughter takes at home:				