

HEATHFIELD JUNIOR SCHOOL
MEDICATION REQUEST FORM

Please print using a black or blue pen.

PRIVATE AND CONFIDENTIAL

Child's Name:		Class:	
Parent/Carer's Name:		Telephone Number:	

I agree to members of staff administering medicines/providing treatment or care as directed below OR I will come into the school and administer medicines myself (<i>delete as applicable</i>)	Name in print: Signed: Relationship to child: Date:
I agree to update the information held by the school about my child's medical needs on a regular basis.	
I will ensure that the medicine held by the school has not exceeded its expiry date.	

Name of medicine	Dose & instrument for administering dose	Times to be given	Completion date of course of medicine if known	Expiry date of medicine

If your child has asthma and their inhaler is not available or has expired, we have an emergency inhaler in school. Please indicate whether you are happy for us to use this inhaler in an emergency situation:

I consent for the emergency inhaler to be given to my child

I do not consent for the emergency inhaler to be given to my child

Any special instructions/additional information/allergies