



Pupil Regular Medication Form

Child's name		
Date of birth/class		
Condition/illness		
Medicine required		
Dosage		
Time/s of day		
Daily until		
Child will self-administer		
Staff to administer		

I agree to update the information held by the school about my child's medical needs as appropriate. This information will be verified by letters/reports from my child's GP and/or consultant.

I will inform the school if and as soon as these instructions change.

I will ensure that all medicine is within its expiry date and is in good condition. I am aware that it is my responsibility to ensure that the school has up-to-date and sufficient medication for my child.

Signed

Date