APPENDIX II
CHILD / YOUNG PERSON MEDICATION REQUEST

Setting name and address: _____

_____

Child / young person's name: _____

Parent's surname if different: _____

Home address: _____

_____

Condition or Illness: _____

☎ Parent's Home no: _____

☎ Parent's Work no: _____

GP Name:_____ Location:_____ ☎ _____

Please tick the appropriate box

☐ My child will be responsible for the self-administration of medicines as directed below.

☐ With supervision ☐ Without supervision

☐ I agree to members of staff administering medicines/providing treatment to my child as directed below.

Name of medicine	Dose	Frequency/times	Completion date of course if known	Expiry date of medicine
Special Instructions:				
Allergies:				
Other prescribed medicines child / young person takes at home:				

NOTE: Where possible the need for medicines to be administered at the setting should be avoided. Parents/Guardians are therefore requested to try to arrange the timing of doses accordingly.

I agree to update information about my child's medical needs held by the setting and that this information will be verified by GP and/or medical Consultant.

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

Signed and agreed:

Child / Young Person

Signature: _____ Date: ____/____/____

Print Name: _____

Parent / Guardian

Signature: _____ Date: ____/____/____

Print Name: _____

School / Setting Representative Agreement:

Signature: _____ Date: ____/____/____

Print Name: _____ Job Title _____