STUDENT MEDICATION REQUEST

Woking High School, Morton Road, Horsell, Woking, GU21 4TJ

Name of School Visit: _____

Date of School Visit: _____

Student's Name: _____Tutor Group: _____

Condition/illness: _____

_____

_____

Parent/Carer Contact Details:

Home: _____ Mobile: _____ Work: _____

Doctor's Contact Details:

G.P. Name: _____ Surgery Name: _____ Phone: _____

Please tick appropriate box:

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

Parent/Carer Signature: _____ Date: _____

Name of medication	Dose	Frequency/times	Completion date of course, if known	Expiry date of medication
Special instructions:				
Allergies:				
Other prescribed medicines taken at home:				