SURREY
COUNTY COUNCIL

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:				