MEDICATION UPDATE FORM

Pupil Name:_____ Date of Birth:_____ Class:_____

Name of Medication	Condition for which prescribed	Prescribed by:	Form E.g. (Tablet/Liquid)	Dose	Frequency	Storage	Additional Equipment Required

I confirm that the information listed above is true and accurate and understand that it is my responsibility to inform the school if there are any changes to the information provided above.

Signed: **Print Name:** **Relationship to Child:**

Date: