The Mead Infant and Nursery School

PUPIL INHALER/MEDICATION REQUEST – 2025/26

Please add Photo
(office use only)

Child's Name: …….. Class…….

Condition or Illness: ……

Parent's Home Telephone No. ……

Parent's Work Telephone No. ……

I agree to members of staff administering medicines / treatments to my child as directed below.

Please complete in capital letters.

Name of Medicine	Dose	Frequency / Time	Expiry date of medicine

Special Instructions:
Allergies:
Other Prescribed medicines child takes at home:

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

- ◯ I give consent for this information to be shared with members of the school community, as appropriate, to ensure the safety and well-being of my child.
- ◯ In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.

Signed: …… Date: ……
(Parent / Guardian)

PUPIL INHALER/MEDICATION LOG – **NAME** ……………………………………………………………………..

Date	Time	Name of Medicine	Dose	Signed