



REQUEST FOR PUPIL TO CARRY MEDICATION

This form must be completed by parents / carers

Details of Pupil:

Surname: _____ Forename(s): _____

Form: _____ Address: _____

Date of Birth: ____ / ____ / ____

Male: Female:

Condition or illness: _____

Medication

Parents must ensure that in date properly labelled medication is supplied.

Name / Type of Medication (*as described on the container*):

Procedures to be taken in an emergency: _____

Contact details:

Name: _____

Phone No Home: _____

Mobile: _____ Work: _____

Relationship to Pupil: _____

I would like my child to keep his / her medication on him / her for use as necessary.

Signature: _____ Date: _____

Relationship to pupil: _____

Agreement of school

We agree that _____ (*name of pupil*) will be allowed to carry and self-administer his / her medication whilst in school and that this arrangement will continue until _____ (*either end date of course of medication or until instructed by parent / carer*).

Signed: _____ Date: _____
(*Office Manager*)

The original should be retained on the school file and a copy sent to the parent / carer to confirm the school's agreement to the named pupil carrying his / her own medication.