



**REQUEST FOR PUPIL TO CARRY HIS/HER MEDICATION**

**AM3**

This form must be completed by parents/carers.

If staff have any concerns discuss this request with healthcare professionals.

**Details of Pupil**

Surname \_\_\_\_\_ Forename(s) \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Class \_\_\_\_\_

Condition or illness \_\_\_\_\_

**Medication**

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

Name of Medicine

Procedures to be taken in an emergency

**Contact Details**

Name \_\_\_\_\_

Phone No (home/mobile) \_\_\_\_\_ (work) \_\_\_\_\_

Relationship to child

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

Signed \_\_\_\_\_ Date \_\_\_\_\_

Relationship to child \_\_\_\_\_

**Agreement of Principal**

I agree that \_\_\_\_\_ (*name of child*) 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 parents*).

Signed \_\_\_\_\_ Date \_\_\_\_\_

(*The Principal/authorised member of staff*)

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