ALEXANDER DICKSON PRIMARY SCHOOL

REQUEST FOR PUPIL TO CARRY MEDICATION

Appendix a

This form must be completed by parents/carers. If staff has any concerns, discuss this request with healthcare professionals.

Details of Pupil

Surname:	Forename(s):
Address:	Date of Birth:
	Class:
Condition of 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 medicine whilst in school and that this arrangement will continue until (either end of course of medication or until instructed by parents.

Signed: (The Principal/authorised member of staff)	Date:

The original should be retained in 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.