REQUEST FOR PUPILS TO CARRY HIS/HER OWN MEDICATION

This form must be completed by Parents/Guardian.

Name of Student		
Tutor group		
Name of Parent/Guardian		
Address	Emergency number	
Medical condition or illness		
MEDICINE		
Name of Medication (as described on the container)		
Date dispensed	Expiry Date:	
Name of Prescriber and contact details		
Quantity of medication to be administered		
Administration details (How much and how often)	How much	Timings
Special precautions		
Further Information • Are there any side effects that the school needs to know about? • Self-Administration Yes/ No (delete as appropriate)		
Procedures to be taken in an emergency		
The above information is accurate to the best of my knowledge at the time of writing. I will inform the school immediately in writing of any changes to the above information. I accept that this is a service that the school is not obliged to undertake. I would like my son/daughter to keep his/her medication on him/her for use as necessary. Parent/Guardian Signature: …… Date: ……..		