

13/09/2017

**CARNINY PRIMARY SCHOOL
REQUEST FOR A PUPIL TO CARRY HIS/HER MEDICATION**

This form must be completed by parents/carers

Details of Pupil:

Surname _____ **Forenames(s)** _____

Date of Birth ____ / ____ / ____ **Class:** _____

Condition or illness: _____

Medication:

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

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

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 instructed by parents.

Signed: _____ **Date:** _____

Principal

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