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) _____

Class _____

Condition _____

Medication

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

Name of Medicine

_____

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** _____

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