Form AM3

BALLYORAN PRIMARY SCHOOL

REQUEST FOR PUPIL TO CARRY HIS/HER MEDICATION

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 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 ____

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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 ___________________

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.