**KILBRONEY INTEGRATED PRIMARY SCHOOL**

**REQUEST FOR PUPIL TO CARRY HIS/HER MEDICATION**

This form must be completed by parents/carers

## Details of Pupil

Surname Forenames(s)

Address

Date of Birth / /

Class

Condition or 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 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**

**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.