Northamptonshire County Council

Request for pupil to carry his/her own medication

IT IS IMPERATIVE THAT MEDICATION IS KEPT SECURE AT ALL TIMES TO PREVENT MISUSE BY THIRD PARTIES - ANY LEADER WILL PROVIDE SECURITY.

This form must be completed by the child's parents/guardian.

Child's name: _____ Tutor group _____

Address: _____

_____

Condition or illness: _____

_____

Name of medicine: _____

Procedures to be taken in an emergency: _____

_____

Contact information

Name (print): _____

Daytime telephone no: _____

Relationship to child: _____

I would like my son/daughter to keep his/her medication on him/her as necessary and I confirm that I have instructed my son/daughter in the proper use of this medication.

Signed: _____ Date: _____

This is based on a form in the DfES publication 'Supporting Pupils With Medical Needs'.