12 Courtenay Hill, Newry, Co Down, BT34 2EA
Phone: (028) 3026 2175

REQUEST FOR A PUPIL TO CARRY HIS/HER OWN MEDICATION

If our staff have any concerns, we will discuss this request with healthcare professionals.

Form to be completed by parents / carers.

DETAILS OF PUPILS

Surname: _____ Forename(s) _____

Address: _____

_____

Date of Birth: _____

Teacher: _____ Primary: _____

Condition or Illness: _____

_____

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

Name of Medication: _____ How Often: _____

Procedures to be taken in an emergency: _____

_____

CONTACT DETAILS

Name: _____

Relationship to Child: _____

Phone Nos: _____

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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 / Vice 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 / Vice Principal)

Principal: Mrs M Monaghan MEd (Educational Management) PQHNI
E-mail: mmonaghan771@c2kni.net