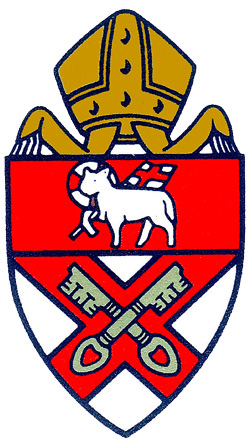
**Request for Pupil to Carry and Self-Administer Medication**

This information will be held securely and confidentially and will only be shared with those who have a responsibility in managing the administration of medication.

This form must be completed by the pupil’s parent before the request can be considered

**Pupil’s Details**

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| Name………………………………………………………………………………………DoB…………….………………………………  Address……………………………………………………………………………………………………………………………………….  Parent/ carer name and contact……………………………………………………………………………………………………..  GP’s name and contact number……………………………………………………………………………………………………...  Emergency contact name and number……………………………………………………………………………………………  Emergency contact name and number……………………………………………………………………………………………. |

**Details of Medication**

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| Medical condition/ illness………………………………………………………………………………………..........................  Medication name and strength……………………………………………………………………………………………………….  Medication formula (eg tablets)……………………………………………………………………………........................... |

**Action to be taken in an emergency**

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| ........................................................................................................................................................  ……………………………………………………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………………………… |

**Parental Request and Statement of Agreement**

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| I (printed name of parent/ carer) ………………………………………………..…………………………………………………   * Request that my son/ daughter carry and self administer the above named medication * Confirm that the information given is accurate and up-to-date * Will inform school in writing of any changes to this information * Understand that the self-administering of the medication will not be supervised by staff * Agree to not hold staff responsible for loss, damage or injury associated with my son/ daughter carrying and self-administering their medication   Signature of parent/ carer ……………………………………………Date………………………………………………………… |

**School Statement of Consent**

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| St Aidan’s CE High School agrees to allow (Name of pupil) ……………………………………………………………….  To carry and self-administer their named medication  Name of Headteacher/ Manager (please print) ………………………………………………………………………………..  Signature of Headteacher/ Manager…………………………………………….Date………………………………………….. |

If more than one medication is to be carried and self-administered then a separate form must be completed for each.