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| --- | --- |
| **FORM MP1****Request for child to carry her/his medicine****THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIANS** | School Crest |

|  |  |
| --- | --- |
| Child’s Name: |  |
| Form Class: |  |
| Address: |  |
|  |  |
| Condition or Illness: |  |
|  |  |

**MEDICATION**

**Parents/Guardians must ensure that in date properly labelled medication is supplied**.

|  |  |
| --- | --- |
| Name of Medicine: |  |
| Procedures to be taken in an emergency: |  |
|  |  |

**CONTACT INFORMATION**

|  |  |
| --- | --- |
| Name: |  |
| Daytime Phone No: |  |
| Relationship to child: |  |

I would like my daughter/son to keep her/his medicine on him/her for use as necessary.

Signed: ……………………………………………….. Date: ………………………………….

**AGREEMENT BY PRINCIPAL**:

I agree that ……………………………………………….will be allowed to carry and self-administer her/his 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 / authorised member of staff

**The original will be retained on the school file and a copy will be sent to the parents/guardians to confirm the school’s agreement to the named pupil carrying his/her own medication.**