**Med Form 3- Request for Pupil to Carry His/ Her Medication and Administer it:**

This form is for parents / carers to complete if they wish their child to carry his / her own medication with the option of also administering it. The school will not give consent unless you complete and sign this form, and the Head teacher or designated person (DHT, PT ASL, PTG) has agreed the request.

**1. To be completed by the parent / carer:**

|  |  |  |
| --- | --- | --- |
| **Pupil Information** | |  |
| **Pupil Surname** |  |  |
| **Pupil Forename (s)** |  |  |
| **Address** |  |  |
| **Postcode** |  |  |
| **Date of Birth** |  |  |
| **Condition or illness** |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication:** | | | | |
| **Name of medication (as described on the container)** |  | | | |
| **How long is your child required to take the medication?** |  | | | |
| **Date dispensed** |  | | | |
| **Full Directions for Use:** | | | | |
| **Dosage and Method** |  | | | |
| **Timing** |  | | | |
| **Special Precautions / any known allergies** |  | | | |
| **Self- Administration** | **YES** |  | **NO** |  |
| **What Administration Support is required** |  | | | |
| **Procedures to take in an Emergency** |  | | | |
| **Emergency Contact Details** | | | | |
| **Name** |  | | | |
| **Telephone Number** |  | | | |
| **Work Phone Number** |  | | | |
| **Relationship to Pupil** |  | | | |
| **Address** |  | | | |

**2. To be completed by the parent / carer and pupil:**

|  |  |
| --- | --- |
| **Parent / Carer Declaration** | |
| I understand my responsibility as parent / carer in ensuring my child has the correct medication they require for the school day. I will provide a safe means for them to carry and access it. I will ensure they are confident in taking the medication as prescribed. | |
| **Signature** |  |
| **Print Name** |  |
| **Relationship to Pupil** |  |
| **Date** |  |

|  |  |
| --- | --- |
| **Pupil Declaration** | |
| I understand my responsibility in school in carrying and taking my medication responsibly as per the prescribed advice. If I lose my medication in school or on school transport, I will report to school staff immediately. | |
| **Signature** |  |
| **Print Name** |  |
| **Date** |  |

|  |  |
| --- | --- |
| **Confirmation of the Head Teacher’s or designated person (DHT, PT ASL, PTG) Agreement to Administer Medication:** | |
| I agree that this pupil will carry and administer the medication identified on this form. If required, the pupil will be supervised / supported with their medication by trained members of staff.  This arrangement will continue until either the end date of course of medicine or until instructed by parents / carers | |
| **Signature** |  |
| **Print Name** |  |
| **Designation** |  |
| **Date** |  |

**Once complete, a copy must be made of this document and given to the parent / carer with the original being stored in the pupil’s PPR.**

|  |
| --- |
| **School Use:** |
| Please ensure a Risk Assessment in completed to accompany this form |