**Parental Request for Student to Carry Medicine for Students with Life Threatening Conditions.**

This form must be completed by parents/guardian.

**Medicines must be carried in their original packaging with the information leaflet and the dispensing label attached.**

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| **Date for Review to be initiated by AHS** | **SEPTEMBER 2018** | | |
| **Name of Student** |  | | |
| **Date of Birth** |  | **Tutor Group** |  |
| **Diagnosed Medical Condition** |  | | |
| **Completed Health Care Plan for condition** | Yes / No | | |

|  |  |
| --- | --- |
| **Medicine** | |
| **Name of Medicine (as described on the container)** |  |
| **Dosage and Method** |  |
| **Side Effects** |  |
| **Procedures to be taken in an Emergency** |  |

|  |  |
| --- | --- |
| **Contact Details** | |
| **Name** |  |
| **Daytime telephone No** |  |
| **Relationship to child** |  |
| **Address** |  |

I would like my daughter to keep her medicine on her for use as necessary

Signature (s)………………………………………..