**REQUEST TO STORE MEDICATION**

I request that the student detailed below be allowed to self-administer the following medicine(s) while at school:

|  |  |
| --- | --- |
| Date |  |
| Name of student |  |
| DOB |  |
| Tutor Group |  |

**The medication MUST be in the original packaging, clearly labelled with the Students name in full.**

The medication should not contain aspirin unless prescribed by the GP.

I understand this will be stored in the school office in a secure place and my son/daughter will attend the office when medicine is required.

My son/daughter will not carry their medication in their bag unless it has been agreed with the Health Care Officer in advance.

The school accepts no responsibility for administering the medication. It will be self administered by the student.

I accept that this is a service which the school is not obliged to undertake and also agree to inform the school of any change to the dosage/duration immediately.

|  |  |  |  |
| --- | --- | --- | --- |
| Medication |  | Expiry Date |  |
| Dose (inc times/quantity) |  | Form | Tablets / Liquid |
| Store in Fridge |  YES/NO | Reason ForMedication |  |

|  |  |
| --- | --- |
| Signed: | Date: |