Appendix D **Wilmslow High School**

Request for student to manage his/her medicine

THIS FORM MUST BE COMPLETED BY PARENTS/CARERS

If staff have any concerns discuss request with school healthcare professionals

Student's Name:

Tutor group:

Address:

Name of Medicine:

Dose and route:

Reason for use:

Procedures to be taken in an emergency:

Contact Information

Name:

Daytime Phone No:

Relationship to student:

I would like my son/daughter to keep his/her medicine on him/her so that they may self-medicate as necessary.

Signed:

Date:

Please note: If more than one medicine is to be carried a separate form should be completed for each one.