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| **PERMISSION TO KEEP MEDICATION WITH STUDENT** |
| Name of student: Form group………………………… |
| Medical condition: |
| Medication Supplied: |
| Parental ConsentI give permission for ……………………………………………………………………. to carry their own medication for self-medication purposes. They will carry…………………………………….. sufficient for the school day.Parent/Guardian Name:Parent/Guardian Signature: Date:………………………………………. |
| Student AgreementI agree that I will carry my own medication securely and I will not pass my medication to any other student.Student Signature: Date:………………………………………… |
| Agreement of Headteacher/Head of YearHeadteacher/HOY signature: Date:………………………………………… |