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| **PERMISSION TO KEEP MEDICATION WITH STUDENT** |
| Name of student: Form group………………………… |
| Medical condition: |
| Medication Supplied: |
| Parental Consent  I 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 Agreement  I 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 Year  Headteacher/HOY signature: Date:………………………………………… |