*FORM C*

**ST NICHOLAS CATHOLIC HIGH SCHOOL**

Request for student to carry his/her own medication (asthma medication/insulin therapy/anaphylaxis medication).

Student Name…………………………………………………………………….. Date of Birth……………….

Address……………………………………………………………………………. Form………………………..

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Known Allergies…………………………………………………….GP Name………………………………….

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| Family Contact 1 | Family Contact 2 |
| Name………………………………………………….Relationship to student……………………………..Address……………………………………………….…………………………………………………………Tel Home……………………………………………..Tel Work………………………………………………Tel Mobile……………………………………………. | Name………………………………………………….Relationship to student……………………………..Address……………………………………………….…………………………………………………………Tel Home……………………………………………..Tel Work………………………………………………Tel Mobile……………………………………………. |

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| Name of medication………………………………………………………………………………………………Strength of medication……………………………………………………………………………………………Directions for useDosage/timing to be given……………………………………………………………………………………….Special precautions……………………………………………………………………………………………….Side Effects………………………………………………………………………………………………………..Procedure to take in an emergency…………………………………………………………………………….………………………………………………………………………………………………………………………Review date……………………………………………………………………………………………………….* I confirm the above named medication has been prescribed by the family doctor or hospital doctor.
* I would like for my son/daughter to keep his/her medication on him/her for use as needed.
* The above information is, to the best of my knowledge, accurate at the time of writing. I will inform the school of any changes to the above in writing.

Signed…………………………………………………………Date……………………………......................Print name…………………………………………………….Relationship to child………………………….. |

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| Head Teacher/ Designated member of staff agreement to administering the above medicationSigned………………………………………………………….Date……………………………………………..Print name……………………………………………………..Position held…………………………………… |