*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 use  Dosage/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 medication  Signed………………………………………………………….Date……………………………………………..  Print name……………………………………………………..Position held…………………………………… |