

**Cranborne Middle School**

**Request for pupils to carry an inhaler on their person**

**The school will consider granting permission for pupils to carry their medication on their person only on receipt of this completed and signed form.**

 **PUPIL DETAILS**

|  |  |  |
| --- | --- | --- |
| Name  | Date of birth  | Tutor Group |
| **MEDICATION****NB: Medicines must be prescribed by the doctor and be in the original container as dispensed by the pharmacy** |
| Name of medication/type of inhaler *(as described on the container)* |
| Name of Doctor prescribing medication: |
| **NB: It is the responsibility of parent/carer to ensure medication has not exceeded expiry date.** |
| Possible side effects: |
| Procedures to take in an emergency: |  |
|  |  |
| * **All inhalers should be clearly labelled with pupil’s name and tutor group**
* **Additional inhaler to be kept in the school office.**

**CONTACT DETAILS** |
| Name | Relationship to child |
| Address | Daytime telephone no. |  |

* The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to my child…………………………………..to carry the medication, described above, on their person.
* I will ensure that my child respects the direction of school staff and acts responsibly when taking medication.
* The school accepts NO responsibility for any adverse reaction to the medication described above.
* I will inform the school immediately, in writing, of any changes to medication or if the medicine is stopped.

Signature…………………………………………………………………Parent/Carer Date………………………………………...

Please print name………………………………………………………..

**...………………………………………………………………………………………………………………………………………..**

Request for ……………………………………..to carry their own medication as detailed above granted / denied (please delete)

Signed........................................................................................................Date…………………………………………………….....

Please print name………………………………………………………..