GOSFORTH CENTRAL MIDDLE SCHOOL
MEDICINES IN SCHOOL

REQUEST FOR CHILD TO CARRY THEIR OWN MEDICINE

PUPIL DETAILS	
Full Name	
Date of Birth	
Registration Class	
Name of Medicine	
Is This Used As An Inhaler For Asthma?	☐ Yes ☐ No
Procedures To Be Taken In An Emergency	

PARENT / GUARDIAN DETAILS		
Title:	☐ Mr ☐Mrs ☐Ms ☐ Miss ☐ Dr ☐ Other *(please specify)* ……	
Surname:		
Forename:		
Relationship to Pupil:		
Telephone Numbers:	**Home:**	
	Mobile:	
	Work:	

EMERGENCY CONTACT 1		
Title:	☐ Mr ☐Mrs ☐Ms ☐ Miss ☐ Dr ☐ Other *(please specify)* ……	
Surname:		
Forename:		
Relationship to Pupil:		
Telephone Numbers:	**Home:**	
	Mobile:	
	Work:	

PARENT/GUARDIAN DECLARATION

I would like my child to keep their medicine on their persons for use as necessary.

Parent / Guardian signature…….. Date……

Print Name…….

ADDITIONAL INFORMATION *(Please use this space to provide any further information that you believe school should be aware of in relation to your child's medical condition).*