

Med form 4

**REQUEST FOR PUPIL TO CARRY HIS / HER MEDICATION**

This form is for parents/carers to complete if they wish their child to carry his / her own medication.

This form must be completed by parents / carers.

Pupil's Name: ..... Class / Form: .....

Address: .....  
.....  
.....

Condition or illness: .....  
.....  
.....

Name of Medicine: .....  
.....

Procedures to be taken in Emergency: .....  
.....  
.....

**CONTACT INFORMATION**

Name: .....

Daytime Phone No.: .....

Work Phone No. ....

Mobile Phone No. ....

Relationship to child: .....

I would like my son / daughter to keep his / her medication on him / her for use as necessary.

Signed: ..... Date: .....

Relationship to Child: .....