# 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: ...........................................................................................................................................