

Request for child to carry his/her own medicine

This form must be completed by parents/guardian

If staff have any concerns discuss this request with healthcare professionals



Name of school/setting

Child's name

Group/class/form

Address

Name of medicine

Procedures to be taken in an emergency

Contact Information

Name

Daytime phone no.

Relationship to child

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

Signed

Date

Office Use Only

Agreed by:

Date