Request for pupil to carry his/her medicine

This form must be completed by parents/guardians if they wish their child to carry his/her medication e.g. inhalers, creams, lotions etc.

Pupil name:_____ Class:_____

Address:_____

_____

_____

Condition or illness:_____

_____

_____

Name of medicine:_____

_____

Procedures to be taken in an emergency:_____

_____

_____

_____

Contact information:

Name:_____

Daytime telephone number:_____

Relationship to child:_____

Signed:_____