FORM 6: REQUEST FOR PUPIL 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	
Name of pupil	
Date of birth	
Group/class/form	
Address	
Name of medicine	
Procedures to be taken in an emergency	

Contact Details:

Name	
Relationship to pupil	
☎ Daytime	
☎ Mobile	
Address	

Parents:

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

Print Parent/Guardian Name:	Signature:
	Date: