

Request for pupil to carry his/her own medication

This form must be completed by the child's parents/guardian.

Child's name:	Study support group:
.....
Address:	
.....	
.....	
.....	
Condition or illness:	
.....	
.....	
.....	
Name of medicine:	
.....	
.....	
Procedures to be taken in an emergency:	
.....	
.....	

Contact information

Name (print):	
.....	
Daytime telephone no:	
.....	
Relationship to child:	
.....	
I would like my son/daughter to keep his/her medication on him/her for use as necessary.	
Signed:	Date:
.....