**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:

............................................................................................................................................