

FORM 7

Request for child to carry his/her medicine

THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN

If staff have any concerns discuss request with school 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: _____

If more than one medicine is to be given a separate form should be completed for each one.