FORM 4 : REQUEST FOR PUPIL TO CARRY HIS/HER OWN MEDICATION

This form is for parents to complete if they wish their child to carry his/her own medication.

This form must be completed by parents/guardian.

DETAILS OF PUPIL

Surname _____

Forename(s) _____

Address _____

_____

_____ Post Code _____

Class _____ Date of Birth _____

Condition/Illness _____

_____

_____

MEDICATION

Name/Type of Medication (as described on the container) _____

Date dispensed _____

FULL DIRECTIONS FOR USE

Dosage and method _____
Timing _____
Special precautions _____
Side effects _____
Self administration Yes / No
Procedures to take in an Emergency _____

CONTACT DETAILS

Name _____ Daytime telephone No: _____
Relationship to pupil _____
Address _____
_____

I would like my son/daughter to keep his/her medication on him/her for use as necessary ☐
Medication has prescription label attached with child's name on it ☐
Medication is in date ☐

Date _____ Signature _____

Relationship to pupil _____