



Request for Pupil to carry their own medicine
This form must be completed by parents/guardian

Pupil Information	
Pupil's name	
Group/class/form	
Address	
Name of medicine	
Dosage	
Does your child need supervision to take medication	YES/NO
Procedures to be taken in an emergency	
Parent/Carer Contact Information	
Name	
Relationship to child	
Address	
Daytime phone no.	

I give permission for my child to keep their medicine on them for use as specified above.

Signed _____ Date _____