

###### FORM 4: REQUEST FOR PUPIL TO CARRY HIS/HER 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 ………………………………………………………………….

Date of Birth ……………………………..

Class ……………………………..

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.

Date ………………………… Signature …………………………………………..

Relationship to pupil …………………………………………………………………