



REQUEST FOR CHILD TO CARRY HIS/HER OWN MEDICINE

This form must be completed by parents/carers

If staff have any concerns discuss this request with healthcare professionals

| | |
|--|--|
| Name of school/setting | |
| Child's name | |
| Tutor Group | |
| Address | |
| Name of medicine | |
| Procedures to be taken in an emergency | |

Contact Information

| | |
|-----------------------|------------------------------|
| Name | |
| Telephone numbers. | (home) (mobile) (work) |
| 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.

