Admin 1b

REQUEST FOR PUPIL TO CARRY HIS/HER PRESCRIBED MEDICATION

Name of School:		Head Teacher:	

Form for parents to complete if they wish their child to carry and administer his/her own prescribed medication (must be completed by parent/guardian)

Pupil's name:		**Date of Birth:**		**Class:**	
Address:					
Condition or illness:					
Name of prescribed medication (dose, times of administration)					
Procedures to be followed in an emergency:					

Contact Information

Name:	
Emergency phone no:	
Relationship to pupil:	

I would like the above named pupil to keep his/her prescribed medication on him/her for use and for him/her to self administer as described above.

Signed:		Date:	
Relationship to pupil:			