

FORM 5

Request for child to carry his/her medication

This form must be completed by parents/carer
Child's name
Class/Form/Group
Address
Condition or illness
Name of medicine
Procedures to be taken in an emergency
Contact Information
Name
Daytime telephone number
Relationship to child
I would like my son/daughter to keep his/her medication on him/her for use as necessary
Signed
Date
Relationship to Child