Form 6 - Request for Child to Carry His/Her Own Medicine

This form must be completed by parents/guardian/pupil over 16 (delete as appropriate)

If staff have any concerns discuss this request with healthcare professionals

Name of School/Setting	
Childs name	
Date of birth	Day / Month / Year
Group/Class/Form	
Address	
Name of medicines	
Procedures to be taken in an emergency	

Contact Information

Name	
Daytime phone number	
Mobile Number	
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.