**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.