MERSEA ISLAND SCHOOL

Request for child to carry his/her own medication

DETAILS OF PUPIL

Full Name: …….

Address: …….

……..

M/F Date of Birth …….. Class: …….

Condition or Illness ……

MEDICATION

Name/type of Medication (as prescribed on the container) …….

Procedure to take in Emergency: ……

Any other information: ……

CONTACT INFORMATION

Family Contact 1

Name ……

Phone No. (work) ……

(home) …….

Relationship ……

Family Contact 2

Name ……

Phone No. (work) ……

(home) …….

Relationship ……

Clinic/Hospital Contact

Name: …….

Phone No. …….

GP

Name: ……..

Phone No. …….

I would like my son/daughter to keep his/her medication on him/her for use as necessary.

Signed ……. Parent/Carer Date ……

If more than one medicine is to be given a separate form should be completed for each one.