Falkirk Council
Children's Services

Med 4

Parent/Carer Request for Pupil to Carry His/Her Medication

TO BE COMPLETED BY PARENT/CARER

Pupil's Name: _____ **DOB**: _____ **Class**: _____

Address: _____

_____

Condition of Illness: _____

_____

_____

Name of Medicine: _____

Procedures to be taken in an emergency: _____

_____

_____

Name of Contact: _____ **Daytime Tel No**: _____

I would like _____ (pupil's name) to keep and administer his/her own medication as necessary.

Signed: _____ **Date**: _____