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: ____

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Condition of Illness: ____

____

____

Name of Medicine: ____

Procedures to be taken in an emergency: ____

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Name of Contact: __________________________ **Daytime Tel No:** ____________________

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

Signed: ____ **Date:** _________________________