Managing Medicines

Parental request for self administration of medication in school/setting

This form must be completed by parents/guardian

If staff have any concerns discuss this request with healthcare professionals

Name of school/setting	
Child's name	
Group/class/form	
Address	
Name of medicine	
Procedures to be taken in an emergency	

Contact Information

Name	
Daytime telephone no.	
Relationship to child	

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

Signed: _____

Dated: _____