KING'S LEADERSHIP
ACADEMY WARRINGTON

REQUEST FOR PUPIL TO CARRY HIS/HER MEDICATION

This form must be completed by parent/guardian

Pupil's Name: _____

Class/Form: _____

Address: _____

_____

Condition or illness: _____

Name of Medicine: _____

Procedure to be taken in an Emergency: _____

CONTACT INFORMATION

Name: _____

Daytime Phone Number: _____

Relationship to child: _____

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

Signed: _____ Date: _____