# Tibshelf Community School

## Request for Child to carry His/Her Own Medicine

This form must be completed by parents/carers/student over 16 (delete as appropriate)

**If staff have any concerns discuss this request with healthcare professionals**

| | |
|---|---|
| Name of School/Setting | Tibshelf Community School |
| Childs name | |
| Date of birth | |
| Form | |
| Address | |
| Name of Medicines | |
| Procedure to be taken in an emergency | |
| Contact Information | |
| Name | |
| Daytime telephone number | |
| Mobile Number | |
| Relationship to child | |

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

Signed _____

Date _____

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