Appendix 4 **FORM: AM5**

REQUEST FOR PUPIL TO CARRY HIS/HER

ASTHMA MEDICATION

This form must be completed by parents/guardian.

Pupil's Name: ______________________________

Class/Form: ______________

Address: ______________________________

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Condition or Illness: ______________________________

____

____

Name of Medicine: ______________________________

Procedures to be taken in an Emergency: ______________________________

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CONTACT INFORMATION

Name: ______________________________

Daytime Telephone No.: ______________

Relationship to Child: ______________________________

I would like my son/daughter to keep his/her medication on him/her for use as necessary. I will take full responsibility for any loss or misuse of the medication.

Signed: ______________________________

Date: ______________

Relationship to Child: ______________________________