Frances' School of Drama (FSD)
Medical Form

NAME ____ CLASS ________________

NAME OF PERSON TO BE CONTACTED IN AN EMERGENCY

____ TEL NO ______________________

ILLNESS/CONDITION ____

MEDICATION ____

WHEN TO BE GIVEN ____

HOW MUCH TO BE GIVEN ____

POSSIBLE SIDE EFFECTS ____

NAME OF DOCTOR ______________________________________ TEL NO ____________________

I give permission for medicine to be given to my child by a member of FSD in accordance with the above.

SIGNED ____

PRINT NAME ____