

# MEDICAL DECLARATION RECORD

## To be Completed by the Worker taking the Medication

I, \_\_\_\_\_, declare that I am required to:  
(Name of worker)

Take medication, as prescribed by my Doctor/Specialist.

Take over-the-counter medication.

## This Medication has the Following Brand or Generic Name.

This medication is prescribed by \_\_\_\_\_.

I purchased this medication over the counter.

# SAMPLE



**ORDER NOW AND GET FULL ACCESS**

All of the information contained in this declaration is true and correct to the best of my knowledge.

Name

Signature

Date

## This Section is to be Completed by the Relevant Manager or Supervisor

Please advise the information provided above and any details of the possible side effects of the medication.

Comments

Name

Signature

Date