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 M... ication ... as the Following Brand or Generic Name.	
☐	...s me... b... e.
☐	...d th... ...c... ...n bef...