

# MEDICAL DECLARATION FORM

## 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.



# SAMPLE

ORDER NOW AND GET FULL ACCESS

All of the information furnished in this Declaration is true and correct to the best of My Knowledge

Name

Signature

Date

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

Please read the information provided above and give details of the possible side effects of the medicament.

Comments

Name

Signature

Date