Parental Consent Form

Administration of Medicine

The completion of this form then enables school to administer your child medicine. School will not give your child medicine unless you complete and sign this form.

Name of Child	
Date of Birth	
Class	
Medical condition or illness	

Medicine

Name/Type of medicine (as described on container)	
Expiry Date	
Dosage and Method	
Timing	
Amount received	
Special precautions/ other instructions	
Are there any side effects that the school need to know about?	
Self-administration Y/N	

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details

Name:	
Contact No:	
Relationship to child	

Parent Signature _____ Date: _____

Staff Signature: _____