CONSENT TO ADMINISTER MEDICINES

The school will not give any medication unless this form is completed and signed.

I request and authorise that my child:

Name: Date of Birth: Form:

Address:

Phone No:

Be given the following medication/gives himself/herself the following medication (delete as appropriate):

Name of Medicine:

Time of Dose: Dose:

Start Date: Finish Date:

The medication has been prescribed for my child by:

Name of GP: whom you may contact for verification. **I have confirmed that it is necessary to give this medication during the school day.**

The medication must be in the original container indicating the contents, dosage and child's full name.

Signed: Parent/Guardian

Date:

School use only:

Date Received: Signed: