CONSENT TO ADMINISTER PRESCRIPTION MEDICINES

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

I request and authorise that my child:

Name: ______________________________ DoB: ______________

Address: ____

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Telephone No: ______________ School: ______________ Class: ________

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

Name of Medication: ____

Time of Dose: ________________ Dose: ____________________

Start Date: ______________ Finish Date: ____________________

This 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: ______________________________________

ADMINISTRATION RECORD

DATE	TIME	DOSE	SIGNATURE	COMMENTS