



Administration of Medicine Parent Consent Form

Please complete the form in full for the school to administer medicine to your child.

Please use a separate form for each medicine.

Date(s) to administer medicine	_____
Child's name	_____
Class	_____
Name of medicine	_____
Strength of medicine	_____
Expiry date	_____
Dose to be given	_____
Time to be given	_____AM/PM
	_____AM/PM
Any other instructions	_____

All prescribed medicines must have your child's name printed on the pharmacy label and be in the original container as dispensed by the pharmacy.

The above information is to the best of my knowledge, accurate at the time of writing. I give consent to school staff to administer the medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the course of medication has been completed.

Signature: _____ Print name: _____

Date: _____