Consent to Administer Medicines

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

I request and authorise that my child

Name_____

Class_____ DOB_____

be given /may give him/herself the following medication:

Name of medication_____ _____ Dose_____

Time of Dose_____Start Date_____Finish Date_____

Name of medication_____

Time of 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 medication during the school day.

Signature:_____Date:_____

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

Date	Time	Medication Administered	Amount	Administered By	Witnessed By

Please note that whilst every effort will be made to give medication at the required time, this may not always be possible.