

# Medication Administration Consent Form

The School will not give your child medicine unless you complete and sign this form.

Name of School	
Name of child	
Date of birth	
Form	
Allergies	
Medical condition or illness	
Name/Type of medicine (as described on the container)	
Date dispensed	
Expiry date	
Dosage and Method	
Times and dates of administration	
Special precautions	
Any known side effects	
Self administration	Yes/No
Who is to administer medication	
Procedures to take in an emergency	
CONTACT DETAILS: Name	
Relationship to child	
Daytime telephone number	

I accept that this is a service the School is not obliged to undertake.  
I understand that I must notify the School of any changes in writing.

Signature(s)

Date