



Medication Consent Form

Name of School	
Name of Child	
Date of Birth (dd/mm/yyyy)	
Medical condition or illness	

Medicine

Name/type of medicine (as described on the container)	
Date dispensed	
Expiry date	
Agreed review date to be initiated by	
Dosage and method	
Timing	
Special precautions	
Are there any side effects that the school needs to know about?	
Self-administration	YES/NO (delete as appropriate)
Procedures to take in an emergency	
Contact Details	
Name	
Daytime telephone no.	
Relationship to child	
Address	

- I understand that I must deliver the medicine personally to Miss Britt and that medicines should be in the same container as dispensed by the pharmacy.
- The above information is to the best of my knowledge accurate at the time of writing and I understand that I must notify the school of any changes in writing.

Date:

Parent's Signature(s)
