Consent for Administration of

Prescribed Medication ☐

OR

Non-Prescribed Medication ☐

Please tick as necessary

Date: _____

Child's Name: _____

Year / Class: _____

I consent/request that my child be given the following medication in school:

Full name of medication: _____

Reason for medication: _____

_____

Time of day to be administered: _____

Time of last dose administered (prior to school): _____

Any other information: _____

_____

Signed: _____ Print Name: _____