Permission to Administer Medicine

Child's details

Name of Child:	Year:

Details of Medication

Name of Medication:	
Dose required:	Time(s) to administer:

What is the reason for the medication?

I GIVE PERMISSION FOR THE ABOVE CHILD TO BE GIVEN THE MEDICINE AS DETAILED AT THE TIME INDICATED ABOVE

SIGNED: …… (Parent/Guardian) DATE: ……..

IN THE EVENT THAT A CHILD REQUIRES MEDICATION AT SCHOOL FOR MORE THAN ONE DAY PLEASE SIGN THE ADDITIONAL SLIPS EACH MORNING CONFIRMING THAT THE ABOVE DETAILS ARE STILL CORRECT.

Additional day 1: SIGNED…… (Parent/Guardian) Date: ……
Additional day 2: SIGNED…… (Parent/Guardian) Date: ……
Additional day 3: SIGNED…… (Parent/Guardian) Date: ……
Additional day 4: SIGNED…… (Parent/Guardian) Date: ……
Additional day 5: SIGNED…… (Parent/Guardian) Date: ……