



Consent for administration of prescribed medication

Name:

Form:

Address:

Date of Birth:

Reason for medication (condition / illness):

Name/Type of Medication:

Dose:

Frequency (inc. dosage at home):

Date dispensed:

How long will you child take this medication:

Signed.....Print Name.....

Date

**ALL MEDICATION SHOULD BE KEPT IN THE ORIGINAL
PACKAGING/BLISTER PACKS INCLUDING INSTRUCTIONS.**