**MEDICINE CONSENT FORM**

To be completed by the parent / carer of any child requesting medicines to be administered on the school premises.

Child’s name…………………………………………. Class…………………………

Address………………………………………………………………….………………

……………………………………………………………………………………………

The doctor has prescribed the following medicine for my child:

……………………………………………………………………………………………

Direction for use – dosage and time to be administered:

……………………………………………………………………………………………

Period medication to be take: date from ….…/….…/….... to ……../….…/….....

Special instruction as to where the medicine is to be stored……..………………..

I confirm my child………………………………….….. is to be given the above medication at the times stated above. I undertake to supply the medication in the original labelled containers provided by the dispensing chemist. I will collect the medication at the end of the course.

Signature of parent / carer……………………………………………………………..

Name……………………………………………………………………………………..

Daytime contact number……………………………..………… Date….../….../……