CONSENT FOR MEDICINE TO BE GIVEN AT SCHOOL

Child's name ____________________________ Date__________________________

Medicine (name) ____

Dose (amount) __________________________

Times medicine to be given ____

Doctor's name ___________________________ Drs Phone No.__________________

Doctor's authorisation attached ❐

Medicine to be given at the above times for ________________ days

Teacher's name ________________________ Room No.____________________

Parent/Caregivers name (printed) ____________________________

Parent/Caregivers signature _________________________________

Medication to be given

DATE	TIME	DOSE	SIGNATURE