NORTH LEGON LITTLE CAMPUS

MEDICATION CONSENT FORM

DETAILS OF PUPIL:

Surname: ……..

First name (s): ……..

Address: ……...

M/F: …….

Date of Birth: ……...

Class: ……

DETAILS OF PERSON GIVING CONSENT:

Name: ……...

Telephone No: ……..

Relationship to Pupil: ……...

Address: ……...

MEDICATION

Name(s) of Medication (**as described on the container(s)**): .....

For how long will your child take this medication: …….

Date dispensed: ……

Name of Medical Doctor/Hospital: .....

FULL DIRECTIONS FOR USE AS AURHORIZED BY THE DOCTOR:

Dosage and amount (**as per instructions on container(s)**): .....

Method (swallow, chew etc.): ……..

Timing: ……

I understand that the medication must be delivered by a responsible adult to an authorized/appointed person in school and accept that this is a service which the school is not obliged to undertake.

Signature:

……...

Date: ……