

MEDICINE CONSENT FORM



MEDICINE CONSENT FORM

Name:	Class:	Name:	Class:
Medicine:	Dose:	Medicine:	Dose:
Time to be administered:	Date:	Time to be administered:	Date:
If medicine required for more than one day, please state days and times required:		If medicine required for more than one day, please state days and times required:	
Reason for administration:		Reason for administration:	
Signed:		Signed:	
Person giving consent:		Person giving consent:	
To be completed by the school nurse:		To be completed by school nurse:	