



## Highcliffe St. Mark Primary School Consent to Administer Medication (September 25-26)

Please complete all the information below. Please use a separate form for each type of medication.

<b>1.0 Child's Information</b>	
<b>Child's Name:</b>	<b>Class:</b>
<b>Reason for Medication:</b>	

<b>2.0 Medication Information</b>	
<b>Medication Name:</b>	<b>Medication Expiry Date:</b>
<b>Time to administer 1<sup>st</sup> dose:</b>	<b>Dose required:</b> (Please make sure the correct dosage syringe or spoon is included.)
<b>Time to administer 2<sup>nd</sup> dose (If applicable)</b>	<b>Dose required:</b>
<b>Medication Start Date:</b>	<b>Medication Finish Date:</b>
<b>Special Instructions (If applicable):</b>	

<b>3.0 Parental Consent</b>	
<b>Parent/Carer Signature:</b> I agree to a member of staff administering medicines as directed above.	<b>Date:</b>
<b>Parent/Carer Name:</b>	<b>Parent/Carer Tel. Number:</b>

<b>4.0 Authorising Signatures:</b> Please print your name and sign	
<b>Checked by:</b>	<b>Date:</b>
<b>Authorised by:</b>	<b>Date:</b>

