Meadows First School
Medication Consent Form
(To be completed by the Parent/Carer)

Child's Name	Date
Date of Birth	Year/Registration
Doctors Surgery	Telephone Number
Name of Medication	Storage Requirements
Dosage and Method	Expiry Date
Frequency 11.00 am or 1.00 pm	Any special instruction
Side effects that school needs to be aware of	

I understand that I must deliver the prescribed medicine personally and that it should be in the same container as dispensed by the pharmacy. The above information is to the best of my knowledge accurate at the time of writing and I understand that I must notify the school of any changes.

I give consent to the administration of the prescribed medicine as details above.

Parent/Carer Name ……

Parent/Carer Signature ……..

Date …….