COLLIS PRIMARY SCHOOL

Medication Administration Consent Form

Child's Name:		Child's Class:	
Parent's Surname (if different):		Home phone number:	
Home Address:			
Emergency contact names and telephone numbers:	1.	2.	3.
Doctor's Name, Address and Contact Details:			
Nature of condition or illness:			

I agree to members of staff administering medicines that have been supplied or providing treatment or care to my child as directed below.	Print Name Parent/legal guardian with parental responsibility
I agree to update information about my child's medical needs, held by the school, on a regular basis.	Sign:
I will ensure that the medicine held by the school has not exceeded its expiry date.	Date:
Procedures to be taken in an emergency:	

Name of medicine	Dose and instrument for administering (e.g. Volumatic, EpiPen/AnaPen)	Frequency/Times	Completion date of course of medicine if known	Expiry date of medicine

Special instructions/timing and dosages of medicines already taken at home/allergies	