



Parental Consent for Administration of Medicines

SCAPA will administer medicine to your child when this consent form is completed and signed. Please use a separate form for each medication.

Date:

Child's Name

Class

Medical condition or illness.....

Name and strength of medicine

Expiry date

Dose to be given

Time to be given

Any other instructions

Medicines must be in the original container as dispensed by the pharmacy

The above information is to the best of my knowledge, accurate at the time of writing. I give consent to the school nurse or school staff to administer the medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the course of medication has been completed.

Signature Print name.....

(Parent)

Date