Prescribed Medication – Permission Form

Name of Student: ____

Date of Birth: ____

Year Level: ____

Medical condition: ____

Medication: ____

Dosage: (times/daily) ____

____

Duration: (dates) From ______________________ to ____________________

Prescribing Doctor: ____

Contact Telephone No.: ____

Side Effects: ____

____

I hereby consent to a School representative administering medication to my child as detailed above.

Name of Parent: ____

Signature: ____

Date: ____

Note: This consent form is only valid for the duration as listed on the prescribed medication and no longer than one year in cases where chronic medication must be administered.