CONSENT FOR STAFF TO ADMINISTER MEDICINES - *Form 2*

The school staff will not administer any medication unless this form has been completed and signed by the parent or carer

I request and authorise that my child be given the following medication:

Name_____ **Date of Birth** _____

Address_____

_____

Phone No_____ **Class**_____

Name of Medication _____

Nature of Condition or Illness_____

Time and frequency of Dose _____

Dosage _____

Expiry Date of Medication _____

Side Effects School Need to Know About_____

Procedures to take in emergency _____

Name of GP who prescribed the medication _____

Telephone No of GP _____

Signed_____**(Parent/Carer) Date** _____

Emergency Contact No _____