



**CONSENT FOR MEDICATION**

**KINDLY COMPLETE AND RETURN TO YOUR CHILD'S CLASS TEACHER. NO MEDICATION MAY BE ADMINISTERED TO YOUR CHILD WITHOUT THIS FORM.**

I \_\_\_\_\_

Parent of \_\_\_\_\_ Grade \_\_\_\_\_

**PLEASE TICK THE APPLICABLE BOX/ES**

**DO** give consent for your office to dispense the following medication to my child should it be necessary

A. PARACETAMOL TABLET

PARACETAMOL SYRUP

NAUSEA/VOMITING/DIARROHEA TABLET

B. Do give permission to administer prescription medicine. This medication is to be supplied to the school by the Parent.

**The timeous re-supply of prescription medication to the school is the sole responsibility of the parent.**

Name of Medication: \_\_\_\_\_ Expiry date: \_\_\_\_\_

Dosage: \_\_\_\_\_ Refrigerate: \_\_\_\_\_

Days and times to be given: ( \_\_\_\_\_ ) ( \_\_\_\_\_ )

( \_\_\_\_\_ ) ( \_\_\_\_\_ )

Special Instructions: \_\_\_\_\_

Possible Reactions: \_\_\_\_\_

Procedure to take in an emergency: \_\_\_\_\_

C. **DO NOT** GIVE CONSENT FOR YOUR OFFICE TO DISPENSE ANY MEDICATION AT ALL.

I understand that this decision is for the duration of my child's schooling at Glenashley Preparatory School. Should I change my mind, I will inform the school in writing

SIGNATURE: .....

DATE: .....

CELL No: .....