



Permission to Give Medication Form

Please complete form in full and hand in with medicines to relevant health centre.
Please ensure all medicines given in to school are still in complete pharmacy administered blister pack or bottle.

Date: _____	
Name of Student: _____ Class: _____	
Any Allergies: _____	
Name of Medication:	How many times a day is medication to be given?
Reason for medication:	Dose to be given (mg, ml):
Time to be given at school with any other instructions for administration:	
Name of parent/guardian:	
Parent/guardian's contact number:	
Signature of parent/guardian:	
Any additional information	