MEDICATION ADMINSTRATION AND CONSENT FORM

****All medication MUST be stored in its original, labelled container and stored out of reach of children AT ALL TIMES. Non emergency medication must be locked up and out of reach of children****

DOUBLE SIDED

Student's Name ____
Surname First

Medication to be given ____

Amount to be given (dosage) ____

I, ____________________, give permission for ________________________ (write name of medication and specific dosage of medication required - i.e. 1.5 ml) to be administered to my child, ________________________, from ________ (mth/yr) to __________ (mth/yr).

Parent Signature________________________________

Type of allergy, if applicable____

Is an Epipen required? Yes _____ No _____

Signs and symptoms indicating an allergic reaction that requires the medication____________________

____

____

Any other special instructions (e.g. to be taken with food...)______________________________

____

____

CONSENT:

I, ________________________ hereby give consent to the teachers and staff of A Child First Preschool Inc. to administer the above listed medication to my child,____________________, in the event that he/she shows any of the signs of an allergic reaction listed above.

______________________________	______________________________
Parent/Guardian's Signature	Receiving Staff's Signature
______________________________	______________________________
Date	Date

Student's Name____
Surname First

DATE	MEDICATION	DOSAGE	TIME	STAFF SIGNATURE	PARENT SIGNATURE