

MEDICATION ADMINISTRATION 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

****IF MORE THAN ONE MEDICATION IS ADMINISTERED, BE SURE TO RECORD EACH ONE ON A SEPARATE LINE****

DATE	**OFFICIAL “MEDICAL” NAME OF MEDIATION ADMINISTERED**	DOSAGE	TIME	STAFF SIGNATURE	PARENT SIGNATURE
<i>March 22, 2018</i>	<i>For example: Salbutamol</i>	<i>1 Puff</i>	<i>1:38pm</i>	<i>*Sample</i>	<i>*Sample*</i>