



Parental Consent Form to Dispense Medicine

IMPORTANT INFORMATION

- *MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS PRESCRIBED AND DISPENSED BY THE PHARMACY.**
- *ONLY MEDICATION THAT IS REQUIRED TO BE TAKEN 4 TIMES A DAY WILL BE ACCEPTED.**

Personal Details

Student's Name	Date of Birth	Form
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Medical Condition/Illness

Please give full information:

Medication

Name of Medicine (as described on the container)		Expiry date
Dosage and Method	Date & Time of Last Dose	Date the course of medicine starts
	Date & Time of Next Dose	Date the course of medicine finishes
Special precautions/Additional Instructions		
Are there any side effects that the school needs to know about?		
Procedures to take in an emergency		

Emergency Contact Details

Emergency Contact 1 (Name and Mobile number) Name:	Emergency Contact 2 (Name and Mobile number) Name:
Mobile:	Mobile
I confirm that the student is able to self-administer the medication.	
Name of Parent/Carer:	Relationship to the student:
Signature of Parent/Carer:	Date:

OFFICE USE ONLY

Record of Date and Time Taken

Date	Time	Dosage	Dispensing Staff's Initials