Small enough for everyone to count

FORM OF CONSENT TO ADMINISTER PRESCRIBED MEDICINE
DATE :
PUPILS NAME (IN FULL) :
CLASS :
I hereby request Mead Road Infant School to administer the medicine prescribed for my child by my doctor, as follows : NAME OF MEDICINE : STORAGE REQUIRED (I.E REFRIGERATE) : DOSAGE : TIME/S : NUMBER OF DAYS TO BE ADMINISTERED (OR UNTIL FURTHER NOTICE): Name of Parent: Signature of Parent/Guardian : _____