Longridge Towers School

CARPE DIEM

LONGRIDGE TOWERS JUNIOR DEPARTMENT
CONSENT FORM FOR ADMINISTERING MEDICINE

Name of child: **Date of Birth:** **Class:**

Description of illness:_____

_____

Medication name & strength:_____

Dosage and timings: _____

_____

Storage: _____

Prescribed by: **Expiry Date:**

I give permission for my child _____ to be given the above dosage of medication at the given times.

Signed: _____ *Date:* _____

Date			
Time given			
Dose given			
Given by			
Witnessed by			

Date			
Time given			
Dose given			
Given by			
Witnessed by			