



Connaught

Junior School

"Caring, Confident, Committed"

Appendix E - LONG TERM PRESCRIBED MEDICATION PERMISSION FORM

CHILD'S NAME:

CLASS:

CONDITION(S) BEING TREATED:

.....

.....

NAME OF MEDICATION(S):

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.....

EXPIRATION DATE(S):

.....

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DOSAGES:

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WHEN REQUIRED:

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POSSIBLE REACTIONS:

I give permission for my child/Connaught Staff to administer Long Term Medication as required.

Parent/Guardian Signature: Date: