



Connaught

Junior School

"Caring, Confident, Committed"

Appendix Fi - PRESCRIBED MEDICATION PERMISSION FORM

CHILD'S NAME:

CLASS:

NAME OF MEDICATION:

EXPIRATION DATE:

DOSAGE:

DATES TO BE GIVEN:

TIMES TO BE GIVEN:

POSSIBLE REACTIONS:

SPECIAL INSTRUCTIONS (shake, refrigerate etc):

I give permission for prescribed medication to be kept in the school office and for it to be administered to my child by an appropriate adult.

Parent/Guardian Signature: Date:

To Be Completed By Staff

	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>
Type of Medication	_____	_____	_____	_____	_____
Dosage Given	_____	_____	_____	_____	_____
Date Given	_____	_____	_____	_____	_____
Time Given	_____	_____	_____	_____	_____
Initials	_____	_____	_____	_____	_____