St James Primary School
MEDICATION CONSENT FORM

First & Last Name of CHILD:			
Type/name of Medication:		Dosage:	Method:
Start Date:	End Date:	Times & Frequency:	
Reason:			
I give permission for the administration of the medication, according to the instructions listed, to the child listed above.			
Date of Authorisation:	Signature (parent / guardian):		

Possible side effects to watch for with this medication:

FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION:	YES	NO
Is the medication consent form complete?	☐	☐
Is the original prescription label on the medication container or pre-packaged and labelled for use by manufacturer?	☐	☐
Is the full name of the child on the container?	☐	☐
Is the prescription or over the counter medication current?	☐	☐
Is the dose, name of drug, frequency of administration given on the label consistent with instructions above?	☐	☐

Staff Initials _____

Comments: