Date Valley School

Parental Consent for administering medication.

I give my permission for the staff at Date Valley School to administer the following medication to my child……………………..…...(Name)	
Name of medication:	
Expiry date of medication:	
Reason medication required:	
Time medication required:	
Dose of Medication required:	
Time period medication required for: (e.g. two days)	
Additional notes: (e.g. Storage or returning medicine)	
Parent signature:	
Staff Signature: (Check details are correct on this form prior to signing)	
Date:	

Please fold after completion to ensure confidentiality.