# Avoncroft Pre-School Nursery
# PERMISSION TO ADMINISTER MEDICATION

Child's Full Name: _____

Date: _____ DoB: _____

Name of Medication: _____

Strength: _____ Method of Administration: _____

Storage: _____ Expiry Date: _____

Dosage: _____ Time of Dosage: _____

Possible side effects expected: _____

Any special instructions (take with food etc):

_____

_____

Was the medication prescribed by a doctor? _____

Name of Doctor Surgery Prescribed by: _____

Start Date of Medication: _____ End Date of Medication: _____

Purpose of Medication: _____

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I release AVONCROFT PRE-SCHOOL NURSERY from any liability from administering this medication.

I hereby give my consent for _____ or a qualified member of staff to administer the above medication to my child, in the amount and at times stated above.

Signed: _____ Date: _____

Print Name: _____ Relationship to child: _____