**PRESCRIBED MEDICATION**

**Medical Consent Form for Prescribed Medication**

***Medication must be in original container as dispensed by pharmacy showing expiry date***

Student name:……………………………………………………………

Student address:……………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………….

Name of medication:………………………………………………….

Strength of medication:…………………………………………….

Dose and frequency to be administered:…………..…….

Quantity of medication given to school:…………………..

Expiry date of medication:……………………………………….

Reason for medication to be administered:……………………………………………………………………….

***Highcliffe School cannot be held responsible for any adverse effects to the student from administering medication and will only hold medication which has previously been given to student by parent***

Has student taken this medication before without adverse effect Yes / No

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Highcliffe School to administer the above. I will inform Highcliffe School immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

Signed:………………………………………………………………….. Parent

Print Name:…………………………………………………………….

Date:………………………………………………………………………

…………………………………………………………………………………………………………………………………………

Office Use: Quantity returned to parent on expiry:……………………………….

Signed:…………………………………………………………………… Date:………………………..