ST THOMAS PRIMARY SCHOOL
MEDICATION CONSENT FORM

Students Name: ____________________________

Grade: ____________________________

Teacher: ____________________________

Illness/Condition: ____________________________

Name of Medication(s): ____________________________

Dates/times to be given: ____________________________

Amount to be given: ____________________________

Emergency Contacts: Parent/Guardian: ____________________________

Phone: ____________________________

Medical Practitioner’s Name: ____________________________

Medical Practitioner’s Phone: ____________________________

Ambulance Cover Yes ☐ No ☐

Ambulance Membership number: ____________________________

I agree that an Ambulance may be called in case of a medical emergency.

I hereby give my permission that this medication to be administered to my child, as I have directed here. I further consent that medical attention may be sought for my child, should it be deemed necessary.

Signature of Parent/Guardian: ____________________________

Date: ____________________________