MEDICAL CONSENT FORM

Childs Name: ..... Room: ……..

Name of Medicine: ……..

Dose to be given: ……..

Time to be given: ……..

Days to be given: ……..

Doctors Name: ……..

Doctors contact no: ……

I request a staff member to assume responsibility for the administration of medication as detailed below, to the above named child. I have provided the medication in its original container which includes the child's name. In requesting this service, I undertake not to hold the staff responsible for any misadventure as a result of administering the medication as specified above.

Parents Name: ……

Signed: …….. Dated: ……..

Parents contact no: ……..