KIDZ ZONE OUT OF SCHOOL CLUB

MEDICATION CONSENT FORM

Child's Name___________________________________ Date of Birth_____________________

Name of medication to be given____

Strength of medication_______________ Prescribing Doctor _____________________________

How medicine is to be stored ____

Expiry Date of Medicine _______________________________

Possible side effects of medication ____

____

Signature of Parent/Carer ____

Date	Dosage Given	Time of Dosage	Witness Signature	Signature of Person Administering Medicine

Medicine Course Completed ____________________________

Medicine Returned on (date) ____________________________

Signed___________________________