RUTHERFORD SCHOOL

MEDICATION CONSENT FORM

Regular Medication Occasional Medication Short Course

Name of Pupil: .....

Date of Birth: .....

Medication and Dose:.....

Reason for medication: .....

Route method of administration: .....

Start date in school: .....

Finish date for short course: .....

Time(s) to be given: .....

Signed by parent / guardian: .....

Print parent / guardian name: .....

Name of doctor who
prescribed above medication: .....

Date: .....