



PERMISSION TO ADMINISTER MEDICINE



Child's name:

Date of birth:

Child's address:

Parent's contact no:

Doctor's name:

Telephone no:

Address of surgery:

Reason for medicine:

Name of medicine:

Storage requirements:

Dosage:

Times to be administered:

I give permission for medicine to be given to my child in accordance with the details above.

Parent's signature:

Parent's name:

Date:

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Staff at the KOT camp will only be permitted to administer medication to your child if you complete and return this form.

- Under no circumstances will members of staff administer medication against the will of a child.
- Note that we can only administer medication containing aspirin if prescribed by a doctor.

Medication receipt log

Medication received on:

Received by:

Medication returned on:

Received by:

Medication received on:

Received by:

Medication returned on:

Received by:

Medication received on:

Received by:

Medication returned on:

Received by:

Medication received on:

Received by:

Medication returned on:

Received by: