PERMISSION TO ADMINISTER MEDICINE

KIDS ON TRACK Andover

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: . . . . . .