**Medical Consent Form for Non Prescribed Medication**

Student name:………………………………………………………..

Student address:……………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………….

Name of medication:………………………………………………….

Strength of medication:…………………………………………….

Dose and frequency to be administered:………………..

Quantity of medication given to school:…………………..

Expiry Date of medication:……………………………………….

Reason for medication to be administered:……………………………………………………………………….

***Highcliffe School cannot be held responsible for any adverse effects to the student from administering medication and will only hold medication which has previously been given to student by parent***

Has student taken this medication before without adverse effect Yes / No

Signed:………………………………………………………………….. Parent

Print Name:…………………………………………………………….

Date:………………………………………………………………………

……………………………………………………………………………………………………………………………………………

Office Use: Quantity returned to parent on expiry:……………………………….

Signed:…………………………………………………………………… Date:………………………..