Medication Administration Consent Form

Name of Child:

DOB:

Medication

Medication Name	Dose	Frequency	Time Administered

(please ensure that all medicines are provided in original containers with boxes, Where appropriate, which clearly displays the prescription information)

Method of administering/ assistance required i.e. drinks or yoghurts to take tablets etc:

Parent or Guardian Consent:

I …… (parent/guardian name) give permission for Pictor Hub to administer the above medication

Signed…… Relationship……

Printed Name…… Date……

GP/Pharmacist

I……confirm that these medications are prescribed to…… (child's name)

Signed…… Date……

Printed Name…… Practise……