



Medication Administration Consent

Non Prescribed Medication Administration Consent

Student's name	Date of Birth
Grade/ Section	
Parent's name	Contact number
Address	
I consent for my child to be given the appropriate medication in the following cases: <input type="checkbox"/> Epinephrine in case of an acute allergic reaction/ anaphylactic shock <input type="checkbox"/> Salbutamol Inhaler to control asthmatic symptoms <input type="checkbox"/> Oral Glucose for hypoglycemia <input type="checkbox"/> Paracetamol to control mild to moderate pain and fever <input type="checkbox"/> Antihistamine for mild allergic reactions	
Precautions that the school nurse needs to know	
Allergies/ side effects/ contraindications that the school nurse need to know	
What should be done in the event of allergy/ side effect/ contraindication	
Parent/Guardian full name	
Parent/Guardian signature	Date