



# Medication Consent Form



Please write in BLOCK CAPITALS

I, \_\_\_\_\_ the

Undersigned parent/ legal Guardian of: \_\_\_\_\_

give consent to:

- The above mentioned use of Topical creams
- The annual medical examination by the designated Doctor
- The administration of the above mentioned 'over the counter' medication should it be required
- Receive First Aid by nursery staff and if deemed necessary to be taken to the nearest Health Care facility to receive medical emergency treatment and or First Aid.

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Date   /   /

