KNIGHTON NORMAL SCHOOL

ADDRESS | 45 Knighton Road, Hamilton, 3216
PHONE | (07) 856 5399
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WEBSITE | www.kns.ac.nz
PRINCIPAL | Stuart Armistead M.Ed. (Educational Leadership), B.Ed., Dip.T.

ADMINISTRATION OF MEDICATION CONSENT FORM

I, _____ being the parent/guardian of _____ in room _____ request that my child be administered the following medication(s) by Knighton Normal School staff.

Name of medication/s: _____

Dosage: _____ at _____a.m._____p.m.

Days: Monday / Tuesday / Wednesday / Thursday / Friday

until _____

If at some time in the future it is discovered that the medication has side effects, I/we will not take any action against the school for administering the medication.

I/we understand and agree that the staff at Knighton Normal School will make "their best effort" to administer the medication as directed and if they are inadvertently unable to do this, then I/we will take no action against them.

Signed: _____ (Parent/Guardian) Date: _____

OFFICE USE ONLY:

	Date	eTap noted
Medication expiry:	_____	Y / N / NA
Request sent for new medication:	_____	
Replacement medication expiry:	_____	Y / N / NA
Request sent for new medication:	_____	
Replacement medication expiry:	_____	Y / N / NA