

# ASHENGROUND COMMUNITY PRESCHOOL



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## Allergy Form/Medical Form

Child's full name: \_\_\_\_\_ D.O.B \_\_\_\_\_

Allergies/Medical info \_\_\_\_\_

Signs and symptoms: \_\_\_\_\_

Medication Used (name) \_\_\_\_\_

Dose to be administered: \_\_\_\_\_ Time/frequency \_\_\_\_\_

Administration of the medication: \_\_\_\_\_

\_\_\_\_\_

When to administer the medication: \_\_\_\_\_

Known Side Effects \_\_\_\_\_

I authorise for Ashenground Community Preschool staff to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent printed name: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Parent Signature \_\_\_\_\_