ANGLICAN DIOCESE OF BRITISH COLUMBIA

Medical Consent Form

Participant Information	
Name of Participant:	
Name of Parent 1:	Name of Parent 2:

Medication
Please list all medication:
Which medication does your child take during the day (during program hours of operation) and at what time?
Does your child need a reminder to take their medication during program hours?
Does your child require assistance with taking their medication during program hours?

Allergies
What sort of reaction does your child have to their allergies?
If they have an Epi-pen, where does your child store it?
Do they need to always have their Epi-pen with them?

I, _____ (Name of Parent) give my permission to this program:

_____ to remind/assist my child with taking their medication at the above-mentioned time during program hours of operation.

Print Name:_____ Signature: _____