Parental Agreement for School to Administer Medicines

The school will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

Date for review to be initiated by _____

Name of school setting _____

Name of child _____

Date of birth _____

Group/Class/Form _____

Medical condition or illness _____

Medicine

Name/type of medicine (*as described on the container)* _____

Expiry date _____

Dosage and method _____

Timing _____

Special precautions/other instructions _____

Are there any side effects that the school/setting needs to know about? _____

Self-administration – Y/N _____

Procedures to take in an emergency _____

NB: Medicines must be in the original container as dispensed by the pharmacy.

Contact details

Name _____

Daytime telephone no. _____

Relationship to child _____

Address _____

_____

_____

_____

I understand that I must deliver the medicine personally to *Miss Annie Hemming (Student Welfare Officer)*

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the Medication or if the medicine is stopped.

Signature _____

Date _____