



Parental agreement for school to administer medicine

The school will not give your child medicine unless you complete and sign this form.

Name of child	
Date of birth	
Class	
Medical condition or illness	

Medicine – only accepted in original container

Name/type of medicine <i>(as described on the container)</i>	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school 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	
I understand that I must deliver the medicine personally to	The School Office

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

Signature(s) _____

Date _____



Record of medicine administered to an individual child

Name of child
 Date medicine provided by parent
 Class
 Quantity received
 Name and strength of medicine
 Expiry date
 Quantity returned
 Dose and frequency of medicine

Staff signature _____

Signature of parent _____

Date
 Time given
 Dose given
 Name of member of staff
 Staff initials

Date
 Time given
 Dose given
 Name of member of staff
 Staff initials
