Parental agreement for school to administer medication

**We are unable to give your child medication unless you complete and sign this form.**

**We can only accept medication that is in the original container as dispensed by the pharmacy**.

|  |  |
| --- | --- |
| Name of school |  |
| Full name of child |  |
| Date of birth |    |    |      |  |
| Group/class/form |  |
| Medical condition or illness |  |
| Daily care requirements (e.g. before sport/lunchtime) |  |
| Describe what constitutes an emergency for the child, and action taken if this occurs |  |
| **Medicine****Note: Medicines must be in the original container as dispensed by the pharmacy** |  |
| Name/type of medicine*(as described on the container)* |  |
| Date received from pharmacy |    |    |      |  |
| Expiry date |    |    |      |  |
| Length of course / treatment |  |
| Dosage and method |  |
| When to be given |  |
| Any other instructions |  |
| Timing |  |
| Special precautions: |  |
| Are there any side effects that the school needs to know about? |  |
| Storage (Fridge etc.) |  |
| Procedures to take in an emergency |  |
| **Contact Details** |  |
| Name |  |
| Daytime telephone no. |  |
| Mobile telephone no. |  |
| Relationship to child |  |
| Address |  |
| Who is the person to be contacted in an emergency (state 2 contacts in preference order) |  |
| Emergency telephone contact no’s. |  |
| Name and phone no. of GP |  |
| Any other information |  |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school staff administering medicine in accordance with the school policy. I understand that I must notify the school in writing of any change in dosage or frequency of medication or if medication is no longer required.

PRINT NAME Signature(s)

DATE: