**Parental agreement for school to administer medicine**

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

|  |  |
| --- | --- |
| Date for review to be initiated by |  |
| Name of school |  |
| 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 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 | [agreed member of staff] |

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