

# Parental Agreement for the School to Administer Medicine

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

## Administration of medication form

Name of child:	
Date of birth:	
Group/class/form:	
Medical condition or illness:	

## Medicine

Name/type of medicine	
Controlled drug:	
Expiry date:	
Dosage and method:	
Timing:	
Will dosage of medicine also be administered by parent before school;	
Special precautions/other instructions:	
Any side effects that the School needs to know about:	
Self-administration – Y/N:	
Procedures to take in an emergency:	
If controlled, named staff:	

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

## Contact details

Name:	
Daytime telephone number:	
Relationship to child:	
Address:	
I understand that I must deliver the medicine personally to:	(Name of staff member)

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 \_\_\_\_\_