

Parental agreement to administer medicine

The school will not give your child medicine unless you complete and sign this form.
Medicines must be in the original container as dispensed by the pharmacy.

Name of child

Date of birth

Class

Medical condition or illness

Medicine

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

Expiry date

Dosage and method

First day of administration

Last day of administration

Timing

Special precautions/other instructions

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

Procedures to take in an emergency

Emergency Contact Details

Name:

Daytime tel no:

Relationship to child:

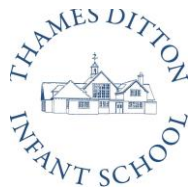
I understand that I must deliver the medicine personally to the school office.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting 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 _____

If more than one medicine is to be given a separate form should be completed for each one.



Record of medicine administered to a child

NAME:

CLASS:

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

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

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