**Administering Medication**

**Parental Agreement Form**

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** |  |
| **Time/s administered at home** |  |
| **Time/s to be administered in school** |  |
| **Special precautions/other instructions** |  |
| **Are there any side effects that the school needs to know about** |  |
| **Self-administration** | **YES  NO** |
| **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** |  |

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 if there is any change in dosage or frequency of the medication, or if the medication is stopped.

**Signature(s)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_