



PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

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

Name of Child	
Date of Birth	
Class	
Medical Condition or Illness	

Medicine

Name/Type of Medicine (as described on container)	
Expiry Date	
Dosage and Method	
Timing/Times	
Special Precautions/Instructions	
Side Effects the School needs to be aware of	
Self-administration Y/N	
Procedure to follow in an Emergency	

Contact Details

	Home	GP
Name		
Address		
Telephone No		

MEDICINES MUST HAVE BEEN PRESCRIBED BY A DOCTOR, DENTIST, NURSE PRESCRIBER OR PHARMACIST PRESCRIBER AND THEY SHOULD ALWAYS BE IN THEIR ORIGINAL CONTAINER AND INCLUDE THE PRESCRIBER'S INSTRUCTIONS FOR ADMINISTRATION.

I understand that I must deliver the medicine personally to a member of staff.

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 dose or frequency of the medicine or if the medicine is stopped.

Signature Dated

Please Print Name