

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.

Name of school Shepeau Stow Primary School
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 _____
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 the agreed member of staff

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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/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s)

Print name

Date