Parental agreement for school to administer prescribed medication

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

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| Name of school/setting |  |
| Name of child |  |
| Date of birth |  |  |  |  |
| Group/class/form |  |
| Medical condition or illness |  |
| Daily care requirements (e.g. before sport/lunchtime) |  |
| Describe what constitutes an emergency for the child, and action taken if this occurs |  |
| **Medicine (Note: Medicines must be the original container as dispensed by the pharmacy)** |
| Name/type of medicine*(as described on the container)* |  |
| Date dispensed |  |  |  |  |
| Expiry date |  |  |  |  |
| Dosage and method |  |
| Time Dosage to be given |  |
| Any other instructions |  |
| Are there any side effects that the school/setting needs to know about? |  |
| Self administration |  |
| Procedures to take in an emergency |  |
| **Contact Details** |  |
| Name |  |
| Daytime telephone no. |  |
| Mobile telephone no. |  |
| Relationship to child |  |
| Address |  |
| Emergency telephone contact no. |  |
| Name and phone no. Of GP |  |

I accept that this is a service that the school/setting is not obliged to undertake.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school/setting staff (or my son/daughter) administering the prescribed medication in accordance with the school/setting policy. I understand that I must notify the school/setting in writing of any change in dosage or frequency of medication or if medication is stopped.

Date Signature(s)