Parental Agreement for School to Administer Medicine

Date: _____

Child's Name: _____ Class: _____ D.O.B: _____

Medical diagnosis/condition: _____

MEDICATION INFORMATION

Name of Medication: _____ Type: _____

Dosage: _____ Expiry Date of Medication: _____

Any Other Instructions: _____

MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY

Medicine to be taken from: _____ (start date) to: _____ (end date)

Time: _____ Special Precautions: _____

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

_____

PROCEDURES TO TAKE IN AN EMERGENCY _____

_____

Name and Phone Number of GP: _____

Emergency Contact Details

Name: _____ Daytime telephone/mobile: _____

Relationship to child: _____ Address: _____

Any other information? _____

I give consent for school staff to administer the above mentioned prescribed medication to my child. I understand that I must deliver/collect the medicine personally to/from the school office. I accept that this is a service that the school is not obliged to undertake. I understand that I must notify the school in writing of any changes in my child's condition/medication.

Parent/Carer Signature: _____

Print Name: _____ Date: _____

Office Use:

Medicine taken from Parent/Carer by: _____

Where will this medication be stored: Medical Cupboard / Fridge / Green Medical Box in Child's Classroom/_____

Do lunchtime staff need to be made aware of this medication? Yes ☐ No ☐