Parental agreement for setting to administer medicine

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

Date for review to be initiated by	
Name of school	
Name of child	
Date of birth	
Class	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Expiry date	
Duration of medication (*please supply end date for school to administer*)	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting 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	[agreed member of staff]

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 schools policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) _____ Date _____