

The school will not give your child medicine unless you complete and sign this form. Please note that medicine which is to be taken three times a day can be administered outside school hours.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of child |  | | | |
| Class |  | | | |
| Medical condition or illness |  | | | |
| Name 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/setting needs to know about? |  | | | |
| Self-administration – y/n |  | | | |
| **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: | Mrs Ousey or Mrs Hutchinson | | | |

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) Date

Administration record

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medicine name | dose | Date/time | Staff administering | Verified  by |
|  |  |  | Name  Signed | Name  Signed |
|  |  |  | Name  Signed | Name  Signed |
|  |  |  | Name  Signed | Name  Signed |
|  |  |  | Name  Signed | Name  Signed |
|  |  |  | Name  Signed | Name  Signed |