**Parental agreement for school to administer medication**

The school will not give your child medication unless you complete and sign this form. The school has a policy where staff can administer medication.

|  |  |
| --- | --- |
| Name of pupil |  |
| Date of birth |  |
| Class |  |
| Medical condition or illness |  |
| **Details of medication** | |
| Type of medication  (please delete as appropriate) | Prescription / Non prescription |
| Name/type of medication (as described on container) |  |
| Expiry date |  |
| Dosage and method of administration |  |
| Timing of administration |  |
| Any special precautions or other instructions |  |
| Can pupil self-administer medication? | YES/NO |
| Procedures to take in an emergency |  |
| **Note: medication must be stored in the original container as dispensed by the pharmacy** | |
| **Contact details** | |
| Name |  |
| Relationship to pupil |  |
| Daytime phone number |  |
| I understand I must deliver the medication personally to |  |

Date of review \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is, to the best of my knowledge, accurate at the time of writing, and I give my consent for the school staff to administer medication in accordance with their policy, and the instructions given with the medication.

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

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_