**Parental agreement for school to administer medication**

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

|  |  |
| --- | --- |
| Name of school | Holy Family Catholic High School |
| Name of child |  |
| Date of birth |  |
| Form |  |
| Medical condition or illness |  |

**MEDICINE**

|  |  |
| --- | --- |
| Name/type of medicine  (as described on the container) |  |
| Expiry date |  |
| Dosage to be given |  |
| Time to be given |  |
| Special precautions/other Instructions |  |
| Are there any side effects that the school need 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 chemist*

**CONTACT DETAILS**

|  |  |
| --- | --- |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |

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

**Signature Date**