**Parental Agreement for School to Administer Medicine**

We will not give your child medicine unless you complete and sign this form in accordance with the school’s policy on administering medicine.

|  |  |
| --- | --- |
| Name of child |  |
| Date of birth |  |  |  |  |
| Form group |  |
| Medical condition or illness |  |
| **Medicine** |  |
| Name/type 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 |  |
| Procedures to take in an emergency |  |
| **Contact Details** |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
|  |  |

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 immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) Date