## Parental agreement for school to administer medication

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

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| Name of child: |  |
| Date of birth: |  |
| Class: |  |
| Medical condition or illness: |  |
| **Medicine** | |
| Name (as printed on the container): |  |
| Expiry date: |  |
| Dosage and method: |  |
| Timing: |  |
| Special precautions: |  |
| Any side effects that the school needs to know about: |  |
| Procedures to take in an emergency. |  |
| Self-Administered | Yes/No |
| **Contact details** | |
| Name: |  |
| Daytime contact number: |  |
| Relationship to child: |  |

|  |  |
| --- | --- |
| I understand that I must deliver the medicine personally to: |  |

*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.*

|  |  |
| --- | --- |
| Name: | Date: |
| Signature: | |