PARENT/CARER 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 telephone no.	
I understand I must deliver the medication personally to:	

This permission is valid for 7 days.

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: _____