



PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER PRESCRIBED MEDICINE

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

Name of child	
Group/class/form	
Date of Birth	
Medical diagnosis or condition	

MEDICINE

Name/type of medicine (as described on the container)

WHEN TO BE GIVEN

Dosage	
Any other instructions	
Expiry date of medication	

Medicines must be in the original container as dispensed by the pharmacy

Agreed review date to be initiated by (name of member of staff)	
Special precautions	
Are there any side effects that the school needs to know about?	
Self-administration (Asthma only)	☐ Yes ☐ No
Procedures to take in an emergency	
Name and telephone number of GP	

CONTACT DETAILS

Contact Name	
Daytime telephone/mobile	
Relationship to child	
Address	
Any other information?	

I give consent for school staff to administer the above mentioned prescribed medication to my child. I understand that I must deliver the medicine personally to (agreed member of staff).

I accept that this is a service that the school is not obliged to undertake.

I understand that I must notify the school in writing of any changes in my child's condition/medication.

Parent/guardian signature	Date
---------------------------	------

If more than one prescribed medicine is to be given a separate form should be completed for each prescription.