Parental Agreement for School to Administer Medicine

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

Name of School	Gaywood Primary School
Name of Child	
Child's Date of Birth	
Class & Year	

Medical Condition or Illness			
Date medicine provided to school			
Name or type of medicine (as on container)			
Expiry Date of Medicine			
Dosage & Method			
Please specify time(s) required			
Special precautions / other instructions / procedures to take in an emergency			
Please specify any side effects			
Self-administration?	Yes		No

Emergency Contact

Name	
Relationship to Child	
Telephone Number	

The above information is, to the best of my knowledge, accurate at the time of writing and I 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 frequency of the medication or if the medicine is stopped.

Signed	
Parent / Carer Name	
Date	

Staff Signature	

Date				
Time Given				
Dose Given				
Name of Staff				
Staff Signature				

Date				
Time Given				
Dose Given				
Name of Staff				
Staff Signature				

Date				
Time Given				
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