Parental agreement for Aldersbrook Primary School to administer medicine

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

Only medicine prescribed by the doctor can be administered.

Name of child	
Date of birth	
Class	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Dates of treatment	from: to:
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school needs to know about?	
Self-administration – y/n	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy. I understand I will need to collect any unused medicine from the school office at the end of the medication period.

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	The School Office

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 (parent/carer) _____Date _____

Record of medicine administered to an individual child (for completion by school staff)

Name of child	
Class	
Name of medicine	
Dose and frequency of medicine	
Dates of treatment	from: to:
To be administered by	
Agreement checked by	

DATE	TIME	DOSE	REACTION?	SIGNATURE OF STAFF	PRINT NAME