PARENTAL AGREEMENT FOR SCHOOL/SETTING TO ADMINISTER MEDICINE

School/Setting	
Date	
Child's name	
Class/Form teacher	
Name & strength of medicine	
Expiry date	
Dosage	
When to be given	
Any other instructions	
Number of tablets/quantity given to school/setting	

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

Contact number of parent/carer	
Name & number of doctor	

Agreed review date to be initiated by (name of member of staff)

THE ABOVE INFORMATION IS, TO THE BEST OF MY KNOWLEDGE, ACCURATE AT THE TIME OF WRITING AND I GIVE CONSENT TO THE NAMED SCHOOL/SETTING STAFF ADMINISTERING MEDICINE IN ACCORDANCE WITH THE SCHOOL/SETTING POLICY. I WILL INFORM THE SCHOOL/SETTING IMMEDIATELY, IN WRITING, IF THERE IS ANY CHANGE IN DOSAGE OR FREQUENCY OF THE MEDICATION OR IF THE MEDICINE IS STOPPED.

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 STAFF CAN ADMINISTER MEDICINE.

Parent's/guardian's signature _____

Print name _____

Date _____

IF MORE THAN ONE MEDICINE IS TO BE GIVEN A SEPARATE FORM SHOULD BE COMPLETED FOR EACH ONE.