



# Parental agreement for School to administer medicine

Name of child	
Date of birth	
Class	
Medical condition or illness	

## Medicine

Name/type of medicine <i>(as described on the container)</i>	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting 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**

## Contact Details

Name	
Daytime telephone no.	
Relationship to child	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the schools policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication.

Signature(s) \_\_\_\_\_

Date \_\_\_\_\_

## Record of medicine administered to child

Date

Time given

Dose given

Name of member of staff


Date

Time given

Dose given

Name of member of staff


Date

Time given

Dose given

Name of member of staff


Date

Time given

Dose given

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