



Parental agreement for school to administer medicine

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

Name of Child: _____

Address: _____

Date of Birth: _____

Class: _____

Medical condition/illness: _____

Medicine

Name/Type of Medicine (as described on the container): _____

No. of tablets/Quantity of medication given to school: _____

Date medication dispensed: _____

Expiry date of medication: _____

Dosage to be given: _____

When to be given:
(Please list if daily/weekly and what time): _____

Special Precautions: _____

Are there any side effects that the school needs to know about? _____

Self Administration: _____ Yes/No (delete as appropriate)

Procedures to take in an Emergency: _____

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





Parent/Carer Contact Details

Name of parent:

Daytime Telephone Number:

Relationship to child:

Address:

Name and contact number of child's GP:

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.

I understand that I must deliver the medicine personally to the School Office

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

I understand that I must collect any medication in person from the school office.

Parent/Carer Signature:

Date:

