Parental agreement for school to administer medicine

NB: medicines must be in the original container as dispensed by the pharmacy

Name of child _____

Date of birth _____

Class _____

Medical condition or illness _____

Medicine (as described on the container)

Name/type of medicine _____

Expiry date _____

Dosage & method _____

Timing of dosage _____

Special precautions/ other instructions _____

Are there any side effects that school needs to know about? Yes / No (please detail)

_____

Procedures to take in an emergency _____

Contact details in case of emergency

Name _____

Contact number _____

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 to administer the 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(s) _____

Date _____