PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

The school will not give your child medicine unless you complete and sign this form, and the school has a policy that the staff can administer medicine.

Date for review to be initiated by	School Office (if applicable)
Name of school	Sun Hill Junior School

Name of child	
Date of birth	
Class name	
Medical condition or illness	

Medicine	
Name/type of medicine *(as described on the container)*	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school needs to know about	
Self-administration : yes/no	
Procedures to take in an emergency	

MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY CLEARLY LABELLED WITH PUPILS NAME AND DISPENCING INSTRUCTIONS AND DATE

Your Contact Details	
Name	
Daytime telephone number	
Relationship to child	
Address	

I understand that I must sign-in this 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 the medicine is stopped. Should the dosage or frequency change I will arrange for a replacement ensuring the dispensing instructions match the instructions given to school.

Signature: _____ Date: _____