ALEXANDER HOSEA PRIMARY SCHOOL

Parental agreement for school to administer medicine

PLEASE COMPLETE THIS FORM IN BLACK INK (put a single line through & initial any errors)

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

MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY

Legal name of child						
Date of Birth	Day		Month		Year	
Class						
Medical condition or illness						
Date medicine provided by parent	Day		Month		Year	
Name/type,strength of medicine (as described on container not brand name)					**Is this a controlled drug? Y / N**	
Expiry date	Day		Month		Year	
Expiry date once opened	Day		Month		Year	
Date when first dose administered	Day		Month		Year	
Dosage and method						
Timing						
Special precautions/other instructions						
Are there any side effects that the school needs to know about?						
Self-Administration? – Y/N						
Procedures to take in an emergency						
CONTACT DETAILS: Name						
Daytime telephone number						
Relationship to child						
Address						

I understand that I must deliver the medicine personally to the school office

QUANTITY RECEIVED IN SCHOOL	
Staff signature (2 signatures req'd if controlled drug)	
Parent/carer signature	
QUANTITY RETURNED TO PARENT	
Staff signature (2 signatures req'd if controlled drug)	
Parent/carer signature	

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.

Parent/carer signature						
Date	Day		Month		Year	