



Parental Agreement to Administer Temporary Medication

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.

Details of Pupil

Name of child: _____

Class: _____ Date of Birth: _____

Medication

Medical Condition			
Name of medication			
Dosage and method			
Dates and times to be taken	Start Date:	Time:	Time:
	Number of days to be taken:		
Special Precautions			
Side Effects			
Can the child self-administer?	Yes / No		
Procedures to be taken in an emergency			

NB: Medicines must be labelled with the child's name and in the original container as dispensed by the pharmacy.

Contact Details

Name: _____

Relationship to child: _____

Daytime Contact Number: _____

I understand that I must deliver and collect the medicine personally to the office Staff.
I agree to the procedures detailed in this plan being administered in school. In the event that these procedures cannot be implemented at any time, the school will follow advice received from the health professionals in summoning the emergency services where appropriate.

Signed: _____ Date: _____



Record of Medication Administered (School Use only)

Name of Child		
Name of medication		Expiry Date:
Quantity Received		Quantity Returned:
Dosage and method		
Storage Location		

Dates and times Medicine Administered (To be completed by staff)

Date:	Time:	Time:
	Dose:	Dose:
	Staff:	Staff:
	Witness:	Witness:

Date:	Time:	Time:
	Dose:	Dose:
	Staff:	Staff:
	Witness:	Witness:

Date:	Time:	Time:
	Dose:	Dose:
	Staff:	Staff:
	Witness:	Witness:

Date:	Time:	Time:
	Dose:	Dose:
	Staff:	Staff:
	Witness:	Witness:

Date:	Time:	Time:
	Dose:	Dose:
	Staff:	Staff:
	Witness:	Witness: