

Eastrington Primary School (Form 3)

PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

8.8

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

Name of Child	
Group/class/form	
Date of birth	
Medical diagnosis or condition	

MEDICATION INFORMATION

Names and types of medications (as described on the container)

Name of medication			
Type			
Dosage			
Any other instructions			
Expiry date of medication			

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

Agreed review date to be initiated by (name of member of staff)	
Special precautions	
Are there any side effects that the school needs to know about?	
Self-administration (Asthma only)	☐ Yes ☐ No
Procedures to take in an emergency	
Name and telephone number of GP	

(more details required overleaf)

CONTACT DETAILS

Contact name	
Daytime telephone/mobile	
Relationship to child	
Address	
Any other information?	

I give consent for school staff to administer the above mentioned prescribed medication(s) to my child. I understand that I must deliver the medicine(s) personally to (agreed member of staff).

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

I understand that I must notify the school in writing of any changes in my child's condition/medication.

I confirm that my child has had this medication without reaction and that their last dose was

administered on.....(date) at.....(time)

Parent/guardian signature	Date
---------------------------	------