



Parental Agreement for the School to Administer Medicine

The school will not give your child medicine unless you complete and sign this form.

Administration of medication form

Date for review to be initiated by	
Name of pupil	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name of medicine	
Expiry date	
Dosage and method	
Timing	
Special precautions and instructions	
Side effects	
Self-administration yes/no	
Procedures for an emergency	

Please note medicines must be in the original container as dispensed by the pharmacy – the only exception to this is insulin, which may be available in an insulin pen or pump rather than its original container.

Contact details

Name	
Telephone number	
Relationship to pupil	
Address	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent for school staff to administer medicine in accordance with the relevant policies. 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 _____

Date _____

Record of Medicine Administered to an Individual Pupil

Date				
Time given				
Dose given				
Name of staff member				
Staff signature				

Date				
Time given				
Dose given				
Name of staff member				
Staff signature				

Record of Medicine Administered to an Individual Pupil (continuation)

Date				
Time given				
Dose given				
Name of staff member				
Staff signature				

Date				
Time given				
Dose given				
Name of staff member				
Staff signature				

Date				
Time given				
Dose given				
Name of staff member				
Staff signature				

Date				
Time given				
Dose given				
Name of staff member				
Staff signature				