Parental Consent to Administer Medicine

The school/setting will not give your child medicine unless it is in accordance with our Supporting Children with Medical Conditions Policy and you complete and sign this form.

Name of child				
Date of birth				
Group/class/form				
Medical condition or illness				

Medicine
(1 medicine per form please)

Name/type of medicine *(as described on the container)*				
Expiry date				
Dosage and method				
Timing(s)				
Special precautions/other instructions				
How long will this medicine be taken?				
Are there any side effects that the school/setting needs to know about?				
Self-administration *(please circle)*	Yes		No	
Procedures to take in an emergency				

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

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
I understand that I must deliver the 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/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s)________________________________ Date ______________

Print Name ________________________________