ADMINISTRATION OF MEDICINES

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.

Date for review to be initiated by	
Name of School	
Name of Child	
Date of Birth	
Class	
Medical condition or illness	

MEDICINE

Name/type of medicine *(as described on the container)*	
Expiry Date	
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	

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

CONTACT DETAILS

Name	
Daytime telephone number	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to:	The School Admin Office

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.

Signature …….. Date…….

Date			
Time Given			
Dose Given			
Staff member who gave medication			
Staff member initials			

Date			
Time Given			
Dose Given			
Staff member who gave medication			
Staff member initials			

Date			
Time Given			
Dose Given			
Staff member who gave medication			
Staff member initials			

Date			
Time Given			
Dose Given			
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