Appendix B

PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER PRESCRIBED MEDICINE

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

Name of School: _____ Class: _____

Name of Child: _____

Date of Birth: _____

Medical condition or illness: _____

Medicine

Name/type of medicine 1
(as described on the container) _____

Date Dispensed Expiry date: _____

Dosage and method: _____

When to be given: _____

Are there any side effects that the school need to know about? _____

Self administration? Yes/no (delete as appropriate).

Procedures to take in an emergency: _____

Name/type of medicine 2
(as described on the container _____

Date dispensed: Expiry Date: _____

Dosage and method: _____

When to be given: _____

Self administration? Yes/no (delete as appropriate _____

Is there a "Care Plan" in place? Yes/no (delete as appropriate)

Contact Details

Daytime telephone no: _____

Name and phone no. of GP: _____

Agreed review date to be initiated by (name of member of staff) _____

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 or if the medication is stopped.

Parent's signature: _____

Print name _____ Date: _____