# Parental agreement for The Three Schools to administer medicine

| | | | |
|---|---|---|---|
| Child's Name: | | | |
| Date of birth: | | Year: | |
| Medical conditon being treated: | | | |

| **Medication** (must be in the original container as dispensed) | | | | |
|---|---|---|---|---|
| **Is the medication prescribed?** | | | | YES/NO |
| **If non-prescribed, I can confirm that my child has previously taken this medication without adverse effects?** | | | | YES/NO NOT APPLICABLE |
| **Name of medication:** | | | | |
| **Expiry date:** | | **Dosage** | | |
| **Dates to be given:** | **From** | | **To:** | |
| **Times to be given:** | | | | |
| **Medication last given/applied** | | | | |
| **Does the medication need to be stored in the fridge?** | | | | YES/NO |
| **Is this oral medication?** | YES/NO | **Self-Administer** | | YES/NO |
| **If not oral, please specify area to be treated:** | | | | |
| **Side effects the school should be aware of:** | | | | |
| **Is the medication to be taken home at the end of the day?** | | | | YES/NO |
| **Is this medication short term?** | | | | YES/NO |
| **If no, date for review:** | | | | |

| **Contact Details in an Emergency** | |
|---|---|
| **Name:** | |
| **Contact number:** | |
| **Relationship to child:** | |

**Consent**

I confirm that the above information is, to the best of my knowledge, accurate at the time of signing and I give my consent to the school staff administering the medication in accordance with the school policy. I will inform the school immediately and in writing if there is any change to any of the above instructions or if the medication is to stop.

| | |
|---|---|
| I am responsible for collecting and delivering the medication from the school office | |
| My child has the responsibility to deliver and collect the medication from the school office. | |

Signature: …… Date: ……

Name: ……

Please print