

Parental Agreement for medications in school

In order for the school to administer regular medications to your child, we request that you complete the following form and return it to school, for the attention to the School Nursing Team.

Please note Emergency Medication should not be included on this form.

Name	
D.O.B	
Address	
Parents name	
Contact number	
School	
Medication Allergies	

*Medicines must be supplied in their original container with a **printed pharmacy label attached**, which states the **child's name, date of birth, medication name, dose and time to be given**. The **medication must also be provided within the expiry date**.*

Medication Name	
Medication Dose (<i>mils/how many tablets/puffs of inhaler</i>)	
Frequency (<i>times per day</i>)	
Exact time medication to be given	
Any other instructions (<i>where to be stored/life span of drug/side effects/emergency use only</i>)	

Medication Name	
Medication Dose (<i>mils/how many tablets/puffs of inhaler</i>)	
Frequency (<i>times per day</i>)	
Exact time medication to be given	
Any other instructions (<i>where to be stored/life span of drug/side effects/emergency use only</i>)	



Medication Name	
Medication Dose (<i>mls/how many tablets/puffs of inhaler</i>)	
Frequency (<i>times per day</i>)	
Exact time medication to be given	
Any other instructions (<i>where to be stored/life span of drug/side effects/emergency use only</i>)	

The above information is correct at the time of writing. **I consent to the school to administer medication in accordance with the school policy.**
I will inform the school nursing team immediately, in writing, if the medication is stopped or any changes are made to the dose or time to be given.

Parent Name(PRINT) and signature	
Date	

Received by member of school nursing team

Name (print) and signature	
Designation and Date	