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| **Administration of medication form** |
| Date for review to be initiated by:  |  |
| Name of child: |  |
| Date of birth: |  |  |  |  |
| Group/class/form: |  |
| Medical condition or illness: |  |
| **Medicine** |  |
| Name/type of medicine*(as described on the container):* |  |
| Expiry date: |  |  |  |  |
| Dosage and method: |  |
| Timing: |  |
| Special precautions/other instructions: |  |
| 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** |

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| **Contact details** |
| Name: |  |
| Daytime telephone number: |  |
| Relationship to child: |  |
| Address: |  |
| 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 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(s) Date