|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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** | | | | |

|  |  |
| --- | --- |
| **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