Administration of Medicines Agreement Form

(to be completed by the Parent/Carer prior to medication being administered by staff)

Child's Name ………………………………………………………………..

Class ……………………………….

Name of Medicine ………………………………………………………………..

Dose ……………………………………………………………………………………..

When to be given / Frequency ………………………………………………………………………………………..

………...

Reason for Medication ……………………………………………………………………………………………….

…….

Medicines must be in the original container/package as dispensed by the pharmacy

Home Telephone Number ………………………………………….

Mobile Number ………………………………………….

I wish for my child's medication to be administered by the school staff. I agree to members of staff administering medicines / providing treatment to my child as directed above and in accordance with the school policy.

Signed …………………………………………………….   Date ……………………. ………….