St. Joseph's
Catholic Primary School

## Template B: parental agreement for school to administer medicine

The school will not give your child medicine unless you complete and sign this form.

| | |
|---|---|
| Date for review to be initiated by | |
| Name of school/setting | St. Joseph's Catholic Primary School |
| 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 | |
| Are there any side effects that the school/setting needs to know about? | |
| Self-administration – y/n | |
| Procedures to take in an emergency | |
| Prescription/Non-Prescription (Delete as appropriate) | Prescription / Non-prescription |

**NB: Medicines must be in the original container as dispensed by the pharmacy**

**Contact Details**

| | |
|---|---|
| Name | |
| Daytime telephone no. | |
| Relationship to child | |
| Address | |
| I understand that I must deliver the medicine personally to | [agreed member of staff] |

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's policy.

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Prescribed Medication: 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. *(delete as appropriate)*

Non-prescription medication: I confirm that I have administered this non-prescription medication, without adverse effect, to my child in the past. I will inform the school immediately, in writing, if my child subsequently is adversely affected by the above medication. *(delete as appropriate)*

If more than one medicine is required a separate form should be completed for each one.

Signature(s) _____ Date _____