Parental Agreement for medications in school

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

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 *(mls/how many tablets/puffs of inhaler)*	
Exact time of Dose	
Any other instructions (*where to be stored/life span of drug/side effects/emergency use only)*	

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Medication Dose *(mls/how many tablets/puffs of inhaler)*	
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Medication Dose *(mls/how many tablets/puffs of inhaler)*	
Exact time of Dose	
Any other instructions (*where to be stored/life span of drug/side effects/emergency use only)*	

As required Medications

Medication Name	
Medication Dose *(mls/how many tablets/puffs of inhaler)*	
Frequency *(times per day),* Spacing *(time between doses)*	
When to be given *(temperature/ as required/pain)*	
Any other instructions (*where to be stored/life span of drug/side effects/emergency use only)*	

Medication Name	
Medication Dose *(mls/how many tablets/puffs of inhaler)*	
Frequency *(times per day)*	
When to be given *(temperature/ as required/pain)*	
Any other instructions (*where to be stored/life span of drug/side effects/emergency use only)*	

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	