Appendix A – Request for Administration of Medicine in School

Parental Agreement to Administer Medicines - Part 1
This school will not give your child medicine unless you complete and sign this form. Please complete the form in **BLOCK CAPITALS.**
Name of Child:
D.O.B: _____ Class: _____
Medical Condition or Illness:
Medicines:
Name/Type of Medicine (as described on the container):
Dosage and Method: **Special Precautions/Other Instructions:**
Are there any side effects that the school /setting needs to know about? **Self-administration: Yes ☐ No ☐**
Procedures to take in an Emergency:
Contact Details:
Parent's Name:
Contact Telephone number:
Relationship to the Child:
Address:
I understand that I must deliver the medicine personally to staff at the school office. The above information is, to the best of my knowledge, accurate at the time of writing and give consent to school /setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. **Parents signature: _____ Date: _____**
To be completed by office staff only. **Medication Returned to School ☐ Form Completed ☐** **Date Received: _____**

Medication Tracing Form						
Ensure that Medication form **Part 1** has been completed first before Administering any Medications.						
Child Name	**Medication (Name of Medication & Dosage)**	**Date**	**Time Medication Administered**	**Dosage**	**Where is Medication kept**	**Staff Name**