**Parental Agreement for Harrison Primary School to Administer Medicine**

**The school/setting will not give your child medicine unless you complete and sign this form and the school or setting has a policy that the staff can administer medicine**

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| Name of Child |  |
| Date of Birth |  |  |  |
| Class |  |
| Medical condition or illness |  |
| **MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY** |
| Medicine |  |
| Form of medicine (i.e. tablet/liquid/cream etc.) |  |
| Expiry date |  |  |  |
| Dosage and method |  |
| Timing |  |
| Special precautions/other instructions |  |
| Are there any side effects that the school needs to know about? |  |
| Self-administration  | YES | NO |
| Procedures to take in an emergency |  |
| Name |  |
| Daytime telephone number |  |
| Relationship to pupil |  |
| Address |  |
| I understand that I must deliver the medicine personally to the school office where receipt of the medicine will be recorded | *Parent/Carer Signature*  |