**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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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* | | | |