Parental Agreement to Administer Prescription/ Over The Counter (OTC) Medicine

Notes to Parent / Guardians

Note 1: This school will only give your student medicine after you have completed and signed this form.
Note 2: All medicines must be in the original container with the instructions for administration and or as dispensed by the pharmacy, with the child's name, its contents, the dosage and the prescribing doctor's name
Note 3: The information is requested, in confidence, to ensure that the school is fully aware of the medical needs of your student.
Note 4: Only prescribed medicines and OTC medicine from the approved list below will be administered
Note 5: OTC medicine will not be administered to children under 6 years of age.

Approved OTC medicines:
Paediatric Paracetamol and Children's antihistamine

Please note all other OTC medicines and/or other medication will not be administered

OTC/Prescribed Medication

Date	
Pupil's name	
Date of birth	
Class	
Reason for medication	

Name / type of medicine (as described on the container)	
Expiry date of medication	
How much to give (i.e. dose to be given)	
Time(s) for medication to be given	
Special precautions /other instructions (e.g. to be taken with/before/after food)	
Are there any side effects that the school needs to know about?	
Procedures to take in an emergency	
I understand that I must deliver the medicine personally to *the school office*	

Number of tablets/quantity to be given	
Time limit – please specify how long your student needs to be taking the medication	_____day/s _____week/s
I give permission for my son/daughter to be administered the emergency inhaler held by the school in the event of an emergency	Yes / No/ Not applicable
I give permission for my son/daughter to carry their own asthma inhalers	Yes / No / Not applicable
I give permission for my son/daughter to carry their own asthma inhaler and manage its use	Yes / No / Not applicable
I give permission for my teenage son/daughter to carry their adrenaline auto injector for anaphylaxis (epi pen)	Yes / No / Not applicable
I give permission for my son/daughter to carry and administer their own medication in accordance with the agreement of the Academy and medical staff	Yes / No / Not applicable

Details of Person Completing the Form:

Name of parent/guardian	
Relationship to student	
Daytime telephone number	
Alternative contact details in the event of an emergency	
Name and phone number of GP	
Agreed review date to be initiated by the responsible person in the school	

I confirm that I give my permission for the Principal (or his/her nominee) to administer the medicine to my son/daughter during the time he/she is at *the school.*

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. I also agree that I am responsible for collecting any unused or out of date supplies and that I will dispose of the supplies.

The above information is, to the best of my knowledge, accurate at the time of writing.

Parent's Signature _____ Date _____
(Parent/Guardian/person with parental responsibility)