**Thomas Johnson Lower School**

Dream-Discover-Flourish

Parental Agreement for School to administer Medicines

The school will not give your child medicine unless you complete and sign this form. The school has a policy that the staff can administer medicines.

|  |  |
| --- | --- |
| Name of Child |  |
| Date of Birth |  |
| Class |  |
| Medical condition/illness |  |

|  |  |
| --- | --- |
| Name of medicine *(as described on the container)* |  |
| Expiry Date |  |
| Dosage and Method |  |
| Timing |  |
| Special precautions/other instructions |  |
| Self-administration *(y/n)* |  |
| Procedures to take in an emergency |  |

**PLEASE NOTE: Medicines must be in the original container as dispensed by the pharmacy**

|  |  |
| --- | --- |
| **Contact Details** |  |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |

**I understand I must deliver the medicine personally to school staff.**

**The above information is, to the best of my knowledge, accurate at the time of writing and I give my consent to school staff administering medicine in accordance with the school policy.**

**Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School staff only:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** |  |  |  |
| **Time Given** |  |  |  |
| **Name of staff member** |  |  |  |
| **Staff initials** |  |  |  |
|  |  |  |  |