|  |
| --- |
| Medical conditions/illnesses: |
| Any known allergies:  |

**Medication Information**

|  |  |
| --- | --- |
| **Name of medicine as described on the container** |  |
| **Label dispense date**  |  |  |  |  |  |  |  |
| **Label expiry date (shelf life before opening)**  |  |  |  |  |  |  |  |
| **Date medication opened** |  |  |  |  |  |  |  |
| **Date of which medication must be discarded** |  |  |  |  |  |  |  |
| **Required dosage** |  |  |  |  |  |  |  |
| **How is medication taken/route?** |  |  |  |  |  |  |  |
| **What time should it be given?** |  |  |  |  |  |  |  |
| **Duration of course** |  |  |  |  |  |  |  |
| **Special precautions?** |  |  |  |  |  |  |  |
| **Side effects?** |  |  |  |  |  |  |  |
| **Has the medication been administered before?** |  |  |  |  |  |  |  |
| **Any changes? E.g. dosage, brand of medication etc.?**  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Parent/carer name and number:** |  |
|  |  |
| **Relevant emergency contact:** |  |
|  |  |
| **GP surgery name and number:** |  |
|  |  |

**Agreement**

* I understand that the medicine must be delivered to school either by me personally or by responsible named adult (adult-adult handover).
* This medicine must have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber.
* I agree to inform the school of any changes in dose of medication as instructed by the doctor / termination of medication immediately, along with a written note from the child’s doctor or a new bottle/package with the new dosage printed on the pharmacy label.
* I accept that only medication prescribed for 4 times a day will be given in school (except in specially agreed circumstances).
* The medication must be provided to school in its original packaging (including outer packaging such as boxes) with pharmacy label stating contents, dosage, expiry date/dispensing date and the child’s name in full.
* I accept that this is a service that the school is not obliged to undertake.
* The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school staff administering medicine in accordance with the school policy.

Parent / carer signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_