**AGREEMENT FOR THE HAWTHORNS PRIMARY SCHOOL TO ADMINISTER MEDICINE**

**It is not possible for us to give your child medicine unless you complete and sign this form**

|  |  |
| --- | --- |
| Name of child |  |
| Date of birth |  |
| Class |  |
| Medical condition or illness |  |

|  |  |
| --- | --- |
| **Medicine** |  |
| Name/type of medicine  *(as described on the container)* |  |
| Expiry date |  |
| Dosage and method |  |
| Timing |  |
| Special precautions/other instructions |  |
| Are there any side effects that the school/setting needs to know about? |  |
| Does your child take it themselves? |  |
| If they do is supervision needed? |  |
| Procedures to take in an emergency |  |
| **NB: Medicines must be in the original container as dispensed by the pharmacy** | |

|  |  |
| --- | --- |
| **Contact Details** | |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
| I understand that I must deliver the medicine personally to |  |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

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