

APPENDIX 2

Parental agreement for pupil to self administer medicine

The school/setting will not accept any medicine onto the premises unless this form is completed and signed.

Name of School	Sacred Heart Catholic Primary School
Date	
Child's name	
Date of birth	/ /
Class	
Medical condition or illness	
Name and strength of medicine (as described on the container)	
Expiry date	
How much to be administered (i.e. dose)	
When to be taken	
Any other instructions	
Are there any side effects that school need to be aware about?	

Note: Medicines must be in the original container as dispensed by the pharmacy.

I understand I am responsible for delivering and collecting the medicine.

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

Daytime phone no. of parent or adult contact.	
Parent's name (print)	
Parent's signature	
Date	
Staff name	
Date	