***The school will not give your child medicine unless you complete and sign this form.***

**Date**: Select today’s date.

**Child details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of child | | Please type full child name here | | |
| Date of birth | | Select date of birth | | |
| Class / Year | | Please type Class / Year | | |
| Medical condition or illness | | Please enter medical condition or illness | | |
| **Medicine details** | |  | | |
| Name/type of medicine  *(as described on the container)* | | Name of medicine as displayed on container. | | |
| Expiry date | | Expiry date | | |
| Dosage and method | | Please type dosage / method here | | |
| Please administer from / to | | From | To (included) | |
| Time(s) of administration | | Time | Time | |
| Special precautions/other instructions | | Please type special precautions/instructions here | | |
| Any side effects that the school needs to know about? | | Please type known side effects if any | | |
| Can your child self-administer? | | Yes or No | | |
| Procedures in an emergency | | Please type emergency procedures if any | | |
| **Parent/Carer Contact Details** | | | | |
| Name | | Please type parent/carer full name | | |
| Daytime telephone number | | Please enter emergency contact number | | |
| Relationship to child | | Choose an item. | | |
| *Please read the statements below and tick the boxes to confirm your agreement:* | | | | |
|  | I understand **that I must deliver the medicine personally to the office** | | |
|  | Medicines must be **in the** **original container as dispensed by the pharmacy**, **with a prescription label where applicable.** | | | |
|  | The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school’s policy. I will inform the school immediately, in writing, if there is any change in dosage / frequency / type of medicine or if it is stopped*.* | | | |