***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*.* |