**Parental Agreement for School to Administer Medicine**

*St. John the Baptist V.A. School needs your permission to give your child medicine. Please complete and sign this form to allow this.*

Name of School

St John the Baptist V.A.School

 / /

Name of child

Date of birth

Group/class/form

Healthcare need

**Medicine**

Name/type of medicine

(as described on the container)

 / /

 / /

Date dispensed Expiry date

Agreed review date to be initiated by [name of member of staff]

Dosage and method

Timing

Special precautions

Are there any side effects that

the school needs to

know about?

Self-administration (delete as appropriate) **Yes/No**

Procedures to take in an emergency

**Contact details**

Name

Daytime telephone no.

Relationship to child

Address

I understand that I must deliver the medicine personally to [*agreed member of staff*]

I understand that I must notify the setting of any changes in writing.

 / /

Date Signature(s) ………………………………………….........