

**Sacred Heart School****Parental agreement for school to administer medicine**

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

Name of Child

Date of Birth

Year

Medical condition or illness

**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

Yes

No

Procedure to take in an emergency

**Contact Details**

Name

Daytime telephone No.

Mobile telephone

Relationship to child

**Address****I understand that I must give written permission for staff to administer medicines****I accept that this is a service that the school is not obliged to undertake****I understand that I must notify the school of any changes in writing.****Signature (s)****Date**