



Parental agreement for setting to administer medicine

Name of school/setting	
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine (as described on the container)	
Expiry date	
Dosage and method	
Timing	
Are there any side effects that the school/setting needs to know about?	
Self-administration – y/n	
Procedures to take in an emergency	

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

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy.

Signature(s).....

Date.....

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Name:

Healthcare Plan Ref: HTL Record of medicine administered to an individual child

Date				
Time given				
Dose given				
Staff signature				
Staff initials				

Date				
Time given				
Dose given				
Staff signature				
Staff initials				

Date				
Time given				
Dose given				
Staff signature				
Staff initials				

Date				
Time given				
Dose given				
Staff signature				

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Staff initials

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