|  |  |
| --- | --- |
| Name of Child |  |
| Date of Birth |  |
| Class |  |
| Medical Condition/Illness |  |
| Name of Medicine (as described on container) |  |
| Date Dispensed (if applicable) |  |
| Expiry Date (if applicable) |  |
| First Dose Given (must be before medicine is given in school) |  |
| Agreed Review Date (if applicable) |  |
| Dosage and method |  |
| Timing |  |
| Special Precautions (are there any side effects the school should know about?) |  |

 **SELF ADMINISTRATION – MEDS HELD BY SCHOOL**

|  |  |
| --- | --- |
| I give permission for my child to self-administer their own medication which is held by school. | **Yes No** |

 **SELF ADMINISTRATION – MEDS HELD BY CHILD**

|  |  |
| --- | --- |
| I give permission for my child to hold their own medication and self-administer when required. | **Yes No**X |
| **Permission granted by school** | **Yes No**X |

 **EMERGENCY PROCEDURES – only for those using Salbutamol inhalers in school**

|  |  |  |
| --- | --- | --- |
| If your child already carries an inhaler in school please state whether or not you give consent for us to administer the school’s supply **in an emergency only** | **Yes No** |  |

**Continued overleaf……**

**CONTACT DETAILS**

|  |  |
| --- | --- |
| Name |  |
| Day time telephone number |  |
| Relationship to child |  |
| Address |  |

**I understand I must deliver the medicine personally to the school office and accept this is a service the school is not obliged to undertake. I have read and understood the Administration of Medicines Policy. I understand I must notify the school of any changes in writing**.

|  |  |
| --- | --- |
| Signature |  |
| Date |  |

**FOR OFFICE USE ONLY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medicine** | **Dosage** | **Date** | **Time** | **Administered by** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |