Parental agreement for the administration of medicine

Date of completion	
Date to be reviewed	
Name of setting	
Name of child	
Class	
Medical condition/diagnosis	

Medicine

Name/type of medicine(as stated on container)	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Any side effects	
Self-administration Yes/No	
Procedures to take in an emergency	

N.B: medicines must be in the original container and box as dispensed by the pharmacy

Contact details

Name	
Address	
Relationship to child	
Phone number (home)	
Phone number (mobile)	

Phone number (work)	
Name	
Address	
Relationship to child	
Phone number (home)	
Phone number (mobile)	
Phone number (work)	

I understand that I must deliver the medication personally to:	Jaimee Fallows, Becky Lamacq or Leeanne Bushell

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the setting staff administering medication in accordance with the settings policy. I will inform the setting immediately, in writing, if there I any change in dosage or frequency of medication or if the medicine is stopped. I understand that it is my responsibility to ensure the setting has a sufficient amount of medication and the medication they have is in date.

Signature _____ Name _____

Data _____