# Agreement to Administer Medicine

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

| | |
|---|---|
| Date for review to be initiated by | |
| Name of academy | |
| Name of child | |
| Date of birth | |
| Group/class/form | |
| Medical condition or illness | |
| | |

**Medicine**

| | |
|---|---|
| Name/type of medicine<br>*(as described on the container)* | |
| Expiry date | |
| Dosage and method | |
| Timing | |
| Special precautions/other instructions | |
| Are there any side effects that the school/setting needs to know about? | |
| Self-administration – y/n | |
| If Yes does the school agree that the child is competent to self administer | |
| Procedures to take in an emergency | To be completed by the school |
| **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 this named member of staff | |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to academy staff administering medicine in accordance with the academy policy. I will inform the academy immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) _____ Date _____