**Parental Agreement for the School to Administer Medicine**

AHS will not administer medicine to your daughter unless this form is completed. **Medicines must be supplied in their original packaging with the information leaflet and the dispensing label attached.**

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| **Date for Review to be initiated by AHS** | **SEPTEMBER 2018** |
| **Name of Student** |  |
| **Date of Birth** |  | **Tutor Group** |  |
| **Diagnosed Medical Condition** |  |
| **Completed Health Care Plan for condition** | Yes / No |

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| --- |
| **Medicine** |
| **Name of Medicine (as described on the container)** |  |
| **Expiry Date** |  |
| **Batch Number** |  |
| **Dosage and Method** |  |
| **Timing/When to be given** |  |
| **Special precautions/other instructions** |  |
| **Side Effects** |  |
| **Self Administered**  | Yes | No | If Possible |
| **Procedures to be taken in an Emergency** |  |
| **Contact Details** |
| **Name** |  |
| **Daytime telephone No** |  |
| **Relationship to child** |  |
| **Address** |  |

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

Prescribed Medication: I will inform the school immediately, in writing, if there is any change in dosage, or frequency of the medication or if the medicine is stopped.

Non- Prescription Medication: I confirm that I have administered this non-prescription medication, without adverse effect, to my daughter in the past/ I will inform the school immediately in writing, if my child subsequently is adversely affected by the above medication.

If more than one medicine is required a separate form must be completed for each one

Signature (s)……………………………………….. Date:…………………………………………………………