Administration of Medicine

Child's name	
Class	
Date of birth	
Medical condition/illness	
Medicines must be in the original container as dispensed by the pharmacy	
Name/type of medication and expiry date	
Dosage and method	
Time to be administered	
Does the school need to be aware of any special precautions or side effects?	
Family Contact Information	
Name of 1st contact	
Relationship to child	
Phone number	

The above information is to the best of my knowledge, accurate and I give consent for school staff to administer the medication in accordance with the school policy. I will inform the school in writing if there is any change in dosage or frequency or if the medication is stopped.

Parent Signature_____ Date_____

Record of administration of medicine

Date	Time given	Dose given	Signature of staff member	Staff initials