Parental Agreement for Medication

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

Date for review to be initiated by:	
Name of child:	
Date of birth:	
Form:	
Medical condition or illness:	

Medicine	
Name/type of medicine (as described on the container):	
Expiry date:	
Dosage and method:	
Timing:	
Special precautions / other instructions:	
Are there any side effects that the Academy needs to know about?	
Permission given for child to carry own medication	Yes / No
Self-administration or supervised in sick bay?	Self / Supervised
Procedures to take in an emergency:	

NB: Medicines must be in the original container as dispensed by the pharmacy.

Contact Details	
Name:	
Daytime telephone number:	
Relationship to child:	
Address:	

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

Signature(s): Date: / /

Print name: