**Administering Medicine Form**

**We will not give your child medicine unless you complete and sign this form**

|  |  |
| --- | --- |
| Name | DOB |
| Class |  |
| Medical Condition |  |
| Name of Medicine |  |
| Medicine Expiry Date |  |
| Dose to be administered | When to be given |
| Side Effects |  |
| Any other instructions |  |
| This arrangement will cease on |  |
| Health Care Plan in place Y/N |  |
|  |  |

Medicines must be prescribed by a healthcare professional and in the original container as dispensed by the pharmacy.

I confirm that the above information is correct and accurate at the time of writing and I give consent to the staff of St.Michael’s Primary School to administer the above medicine in accordance with the school policy.

Parent/Carer Signature Date

Print Name

Staff to fill in below when administering medicine:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date  | Time | Amount | Staff | Notes |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |