OAKLANDS PRIMARY ACADEMY

PARENTAL AGREEMENT FOR OAKLANDS TO ADMINISTER PRESCRIBED MEDICINE

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

Name of Child Class
MEDICINE Name/type of medicine _____ *[As described on the container/packaging]*
Start date _____ End date _____
Time of administration _____
Are there any side effects that we should be aware of? YES / NO *[Please delete as applicable]* *If 'YES' please state* _____
Self-administration? YES / NO *[Please delete as applicable]*
Procedures to take in an emergency
Is there a 'Care Plan' in place YES / NO *[Please delete as applicable]*
The above 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 policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency or if the medication I stopped. Name _____ Signature _____ Date _____ Relationship to child _____
EMERGENCY CONTACTS: NAME _____ Signature _____ Nº. _____ NAME _____ Nº. _____