

**For school use only**



# Glebe Junior School

<b><u>MAR completed</u></b>	<b><u>Storage Location</u></b>

## **Parental Consent for School to Administer Medicine**

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

**Note: Medicines must be in the original container as dispensed by the pharmacy and labelled with your child's full name.**

Date

Childs name

Date of birth

Group/Class/Form

Medical condition or illness

**Medicine**

Name/type of medicine/strength  
*(as described on the container)*

Date dispensed

Expiry date

Dosage and method

Timing – when to be given

Special precautions

Any other instructions

Number of tablets/quantity to be given to School/Setting

Are there any side effects that the School/Setting needs to know about?

Self administration

Procedures to take in an emergency

**Contact Details – First Contact**

Name

Daytime telephone number

Relationship to child

Address

**Contact Details – Second Contact**

Name

Daytime telephone number

Relationship to child

Address

Name and phone number of G.P.

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

I understand that I must deliver the medication personally to the school office.  
I accept that this is a service that the School/Setting is not obliged to undertake.  
I understand that I must notify the School/Setting of any changes in writing

Parent's Signature \_\_\_\_\_

Print name \_\_\_\_\_

Date \_\_\_\_\_

If more than one medicine is to be given a separate form should be completed for each one.

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Checked by	Date	Signature	note

**To be reviewed annually or if dose changes** (LONG TERM MEDICATION ONLY)

Review date