**This document is protected. Click the grey box in each section to complete the form.**

**PARENTAL CONSENT TO ADMINISTER MEDICINES**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of young person |  | | DOB | |  | |
| Group/class/form |  | | | | | |
| Medical condition or illness |  | | | | | |
| **Medicine** |  | | | | | |
| Name/type of medicine  (as described on the container) |  | Expiry date | | (yyyy/mm/dd) | | |
| Self-Administration | | Yes | | No |
| Dosage and method |  | Timing | |  | | |
| Special precautions/other instructions |  | | | | | |
| Are there any side effects that the school/college needs to know about? |  | | | | | |
| Procedures to take in an emergency |  | | | | | |
| **NB: Medicines must be in the original container as dispensed by the pharmacy.  A correct supply of the most recently dated medicine is required.** | | | | | | |
| **Contact Details** |  | | | | | |
| Name |  | | | | | |
| Daytime telephone no. |  | | | | | |
| Relationship to young person |  | | | | | |
| Address |  | | | | | |
|  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| Signature(s) |  | Date |  |