

# Agreement for administration of Medication

Reviewed (date) \_\_\_\_\_



## General Information

Name of Pupil			
Address			
Date of Birth		Male <input type="checkbox"/>	Female <input type="checkbox"/>
Class			
Medical Condition			
Describe medical condition and give details of pupil's individual symptoms			

## Medication

Name of Medication			
Strength of medication (as appropriate)			
Form of medication (tablet, liquid etc.)			
Dosage of medication			
Method and time of administration			
Daily Care Requirements / Special precautions (e.g. before sports, nursing needs)			
Action to be taken in an emergency			
Follow up care / Side Effects			
How long will your child take this medication?		Date dispensed / /	

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The information on this form should be reviewed every 28 days in accordance with Care Commission recommendation.**

