



Parental Agreement to Administer Medicine

Name of Student

Date of Birth

Group/Class/Form

Medical Condition

Medicine

Name/Type of Medication
(as described on the container)

Expiry date

Dosage and Method

Timing

Special Precautions/Other
Instructions

Are there any side effects that the
school/setting needs to know
about?

Self-administration – y/n

I give consent for my son / daughter to take the above medication as required and understand that the school will keep a signed record of all medication taken.

Signature of Parent / Guardian	
Print Name	
Date	

