

**Parental agreement for Reach to administer medicine.**

Name of child	
Date of Birth	
Medical condition or illness	
<b>Medicine: to be in original container with label as dispensed by pharmacy</b>	
Description of Medicine (as described on container)	
Date administration to commence	
Dosage and method	
Time/s to be administered	
Any special precautions	
Are there any side effects that the school should know about?	
Self-administration	Yes/No (delete as appropriate)
<b>I understand that I must deliver the medicine safely to Reach reception/main office. I give my consent for school staff to administer medicine. I will inform Reach immediately, if there is any change in dosage or frequency of the medication or if the medicine is stopped.</b>	
Parents signature	
Print name	
Date	