KITE RIDGE SCHOOL
CHANGING MINDS

Parental agreement for school to administer Buccal Midazolam

THIS FORM MUST BE COMPLETED BY PARENT/GUARDIAN

Child's name	
Child's date of birth	

Name and strength of medicine	
Date dispensed	
Expiry date	
Dose to be given	
When to be administered (timing)	
Can a second dose be administered and when?	
Possible side effects	
Any other instructions	

Please note that Medicines must be sent to school in the original container as dispensed by the pharmacy

Name of parent/guardian to be contacted in an emergency	
Daytime phone numbers	
Name and phone number of GP/consultant who authorised this medication	

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

Signature: ______________________________________ **Date:** ____________________

For office use:

GP/CONSULTANT AGREEMENT:

Name of medicine ____________________________________

Confirmation of dosage ___________________________

Date: ______________________