**PARENTAL AGREEMENT FOR SCHOOL TO**

**ADMINISTER MEDICINE**

The school will not give your child medicine unless you complete and sign this form, and the school has a policy that staff can administer medicine.

|  |  |
| --- | --- |
| NAME OF SCHOOL | MILVERTON COMMUNITY PRIMARY SCHOOL |
| NAME OF CHILD |  |
| DATE OF BIRTH |  / /  |
| CLASS |  |
| MEDICAL CONDITION OR ILLNESS |  |

**MEDICINE**

|  |  |
| --- | --- |
| NAME/TYPE OF MEDICINE(as described on the container)  |  |
| DATE DISPENSED |  / / |
| EXPIRY DATE |  / / |
| DOSAGE AND METHOD |  |
| TIMING |  |
| SPECIAL PRECAUTIONS |  |
| Are there any side effects that the school needs to know about? |  |
| Self Administration | YES/ NO (delete as appropriate) |
| Procedures to take in an emergency |  |

**CONTACT DETAILS**

|  |  |
| --- | --- |
| NAME |  |
| RELATIONSHIP TO CHILD |  |
| DAYTIME CONTACT NUMBER |  |

I understand that I need to deliver the medicine personally to the school office.

I accept that is a service that the school is not obliged to undertake.

I understand that I must notify the school of any changes in writing.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_