

PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

The school will not give your child medicine unless you complete and sign this form and hand it in to the school office along with the medication.

PUPIL DETAILS

Name of school	<input type="text"/>
Name of child	<input type="text"/>
Date of birth	<input type="text"/>
Class	<input type="text"/>
Medical condition or illness	<input type="text"/>

MEDICINE

Name/type of medicine (as described on the container)	<input type="text"/>
Date dispensed	<input type="text"/>
Expiry Date	<input type="text"/>
How much to give	<input type="text"/>
When to be given	<input type="text"/>
Special precautions	<input type="text"/>
Are there any side effects that the school needs to know about?	<input type="text"/>
Procedures to take in an emergency	<input type="text"/>

CONTACT DETAILS

Name	<input type="text"/>
Daytime telephone number	<input type="text"/>
Relationship to child	<input type="text"/>

- I understand that I must deliver the medicine personally to the school office and that medicines should be in the same container as dispensed by the pharmacy.
- I accept that this is a service that the school is **not** obliged to undertake.
- The above information is to the best of my knowledge accurate at the time of completing this form and I understand that I must notify the school of any changes in writing.
- I am aware that it is **my** responsibility to provide the medication and ensure it does not pass beyond its expiry date.

Parent's signature
Print name
Date

