



Parental agreement for school to administer medicine

The school will not give your child medicine unless you complete and sign this form.
NB: Medicines must be in the original container as dispensed by the pharmacy.

Name of child	
Date of birth	
Class	
Medical condition or illness	

Medicine

Name/type of medicine <i>(as described on the container)</i>		
Expiry date		
Dosage and method		
Timing		
How many days will your child need this medicine?		
Are there any side effects that the school needs to know about?		
Self-administration	Yes	No
Prescription/ Non-prescription	Prescription	Non-prescription
Procedures to take in an emergency		

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	Mrs H Blay

Please sign the back



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's policy.

Prescription: 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.

Non-prescription: I confirm that I have administered this non-prescription medication, without adverse effect, to my child in the past. I will inform the school immediately, in writing, if my child subsequently is adversely affected by the above medication.

Signature _____

Date _____