Parental Agreement for School to Administer medicine

The school will not give your child medicine unless you complete and sign this form.

Pupil Details

Child's name _____ Class/Year _____

Date _____

Medication Information

Name of medicine _____ Strength _____

Expiry date _____ Dose _____

Time to be given _____

Number of tablets/quantity to be given to the school _____

Note: medicines must be in the original container as dispensed by the pharmacy.

Parent Information

Name of Parent _____

Daytime Number _____

GP Information

Name of GP _____ Telephone _____

Name of Surgery _____

Agreed review date _____

The above information is, to the best of my knowledge, accurate at time of writing and I give consent to the school for 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 medicine of if the medicine is stopped.

Parent's Signature _____ Date _____

Print Name _____