ASHURST CE AIDED PRIMARY SCHOOL

PARENTAL AGREEMENT
FOR SCHOOL TO ADMINISTER MEDICINE

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

Date for review to be initiated by	
Name of child	
Date of birth	
Class	
Medical condition or illness	

MEDICINE

Name/type of medicine (as described on the container)	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school needs to know about	
Self-administration (y/n)	
Procedures to take in an emergency	

NB:
MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY

CONTACT DETAILS

Name	
Daytime telephone no	
Relationship to child	
Address	
I understand I must deliver the Medicine personally to:	School Office

The information is, to the best of my knowledge, accurate at the time of writing and I give consent to the 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: _____