## PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

The school w	vill no	t give you	ır child 1	medicine	unless y	ou c	complete	and	sign	this	form,	and	the
school has a	policy	that the	staff car	n adminis	ster medi	cine	<u>.</u>						

Name of child  Date of birth  Class name  Medical condition or illness  Medicine  Name/type of medicine (as described on the container)  Lixpiry date  Dosage and method  Timing Special precautions/other instructions  Are there any side effects that the school needs to know about  Self-administration: yes/no  Procedures to take in an emergency  MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY CLEARLY LABELLED WITH PUPILS NAME AND DISPENCING INSTRUCTIONS AND DATE  Your Contact Details  Name  Daytime telephone number  Relationship to child  Address  I understand that I must sign-in this medicine personally to the School Office  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 policy. I will inform the school immediately, in writing if the medicine is stopped. Should the dosage or frequency change I will arrange for a replacement ensuring the dispensing instructions match the instructions given to school.	Date for review to be initiated	l by School Office (if applicable)					
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