



## Parental Agreement for School to Administer Prescribed Medication

Child's Name: ..... DOB: ..... Form: .....

Name and strength of medicine: .....

How much to be given (dose): .....

Time/s to be given: .....

Duration (how many days): .....

Special Instructions: .....

.....

*The school will not administer any medication unless this form is completed fully and signed.*

*A separate form must be completed if **more than one** medicine is to be given.*

*N.B Medicines must be supplied in the original container as dispensed by the pharmacy*

The above information is to the best of my knowledge, accurate at the time of writing and I give consent for school staff to administer medication in accordance with the school policy.

I confirm that my child has received at least one dose of the above medication previously and without adverse effect.

Parent/Guardian Name: .....

Parent/Guardian Signature: .....

Daytime contact number of parent/Guardian: .....

Date: .....