RETTENDON PRIMARY SCHOOL

Parental agreement for the school to administer medicine

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

Date	
Child's Name	
Class	
Name and strength of medicine	
Expiry Date	
How much given (i.e. dose)	
When to be given	
Any other instructions	
Number of tablets/quantity to be given to school	

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

Daytime phone no. of parent or adult contact	
Name and phone no. of GP	

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 there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent's Signature ________________________________

Print Name ______________________________________ Date _____________