



**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:		CONTACT DETAILS	
Name of child		Name	
Date of Birth		Daytime Telephone no.	
Class		Relationship to child	
Medical condition or illness		I understand I must deliver Medicine personally to the School Office	
MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY			
Name/type of medicine		Special precautions / other instructions	
Expiry Date		Are there any side effects that the school needs to know about?	
Dosage and method		Self-administration (y/n)	
Timing		Procedures to take in an emergency	
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.			
Signed:		Date:	