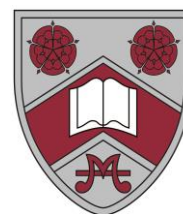


## Parental Agreement for School to Administer Medicine

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



Name of School: Penwortham Girls' High School

Date:	
Date for Review:	
Name of Pupil:	
Date of Birth:	
Form:	
Medical condition or illness:	

### Medicine

Name/type of medicine (as described on the container)	
Date dispensed	
Expiry date	
Dosage and method	
Timing/frequency	
Special precautions/other instructions	
Any side effects?	
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	
Relationship to pupil	
Daytime telephone number	
Address	

*(Continued overleaf)*

I understand that I must deliver the medicine personally to:	Mrs L McLean (school reception)

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 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 medication is stopped.

Sign (Print name):\_\_\_\_\_ Date:\_\_\_\_\_

Signature(s):\_\_\_\_\_

Agreed Review Date:	
Review to be initiated by:	