# 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: | |