Parental agreement for school to administer medicine

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

Name of school	Spaldwick Primary School				
Name of child					
Class/form					
Medical condition or illness					
Medicine Name/type of medicine and strength (as described on container)					
Date dispensed					
Expiry date					
Dose to be given					
Time/s to be given					
Any special precautions (eg. before food)					
Note Medicines must be in the original container as dispensed by the Pharmacy Contact details					
Daytime no. of parent or adult to contact					

Name and phone no. of GP

I accept that this is a service that the school is not obliged to undertake. I understand that I must notify the school of any changes in writing.

Date

Signature

Date	Dose	Time	Signature of Staff	Witness Name