HIPPINGS METHODIST PRIMARY SCHOOL

Parental Agreement for school to administer prescribed medicines

The school will not be able to give your child medicine unless you complete this form.

Name of School ----------

Name of Child ----------

Date of Birth ----------

Class ----------

Medical condition / Illness ----------

Medicine

Name the medicine is prescribed to on the container ----------

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Name / Type of medicine ----------

Date dispensed ----------

Expiry date ----------

Dosage and method eg Oral, inhaled: ----------

Timing ----------

Special Precautions ----------

Side effects we need to know about ----------

Self Administration YES / NO (delete as appropriate)

Procedures to take in an emergency ----------

Signature ---------- Date----------