FORM 3A/B

Parental agreement for school to administer medicine

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

Name of School **St Peters CE Primary**

Child's Name_____ Date_____

Group/Class/Form_____

Name and strength of medicine_____

Reason for medication (eg. Cough medicine) _____

Expiry date of medicine_____

How much to give (i.e. dose to be given)_____

When to be given (time of day)_____

Any other instructions_____

Note: Medicines must be the original container as dispensed by the pharmacy.

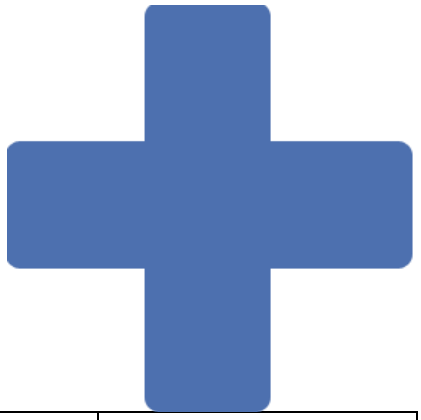
The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent's signature:_____ Print Name:_____

Parent contact number_____

Handed to (Staff name)_____

Record of medicine administered to an individual child



Name of child_____

Date medicine provided by parent_____**Group/class** _____

Date	Time Given	Dose Given	Administered by (Staff name)&initial

If more than one medicine is to be given a separate form should be completed for each one