

Class

Signed

Date

I understand that I must deliver medicines to the school office

I accept that this is a service that the school is not obliged to undertake

I understand that I must notify the school of and changes to the details above

Contact numbers

**Contact Details** ects?

Parent/Carer Name

Relationship to child

Procedures in case of emergency

Any side effects?

Special Precautions

Timing

Medical Condition/illness

Dosage and Method

Date Dispensed

Name/Type of medicine

Expiry Date

Date of birthBirth

Name of Child

**PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE**