

Parental agreement for medicine to be taken at School

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

Name of school/setting	St. Peter's Catholic High School
Date	/ /
Child's name	
Group/class/form	
Name and strength of medicine	
Expiry date	/ /
Dose	
Timings	
Any other instructions	
Number of tablets/quantity to be given to school/setting	

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

Daytime phone no. of parent or adult contact	
Name and phone no. of GP	
Agreed review date/member of staff to review	

The above information is, to the best of my knowledge, accurate at the time of writing. I give consent to school/setting staff storing medicine. I also give my consent for my child to take the medicine whilst at school with the above instructions in accordance with the school/setting policy. I will inform the school/setting 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 _____

Date _____

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