Whingate Primary School

PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

Name of child Class	
Medical condition	
Name of medicine	
Quantity supplied	
Dose	
Frequency	
Time to be given	
Expiry date of medicine	
Other instructions	SHORT OR LONG TERM?
Self-administration	**YES / NO**

Note: medicines must be in original container as dispensed.

I give consent to school staff administering medicine in accordance with the school policy. I accept that this is a service that the school is not obliged to undertake. I understand I must notify the school of any changes in writing.

Date _____

Parent Signature _____ First Aider Signature _____

Administered By:_____ Date:_____ Time:_____
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