Parental agreement for Wigmore Primary School to administer medicine during school hours

The school be unable to give your child prescribed medicine unless you complete and sign this form.

Name of school	Wigmore Primary School
Date	----------
Child's name	----------
Class	----------
Name & strength of medicine	----------
Expiry date	----------
Dosage	----------
Timing/s	----------
Any other instructions	----------
Tablets: quantity handed in	----------
Or Bottle of medicine?	----------

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

Daytime contact number _____

Name and Number for GP _____

Agreed review date to be initiated by (Staff member) _____

The above information is, to the best of my knowledge, accurate at the time of writing and I consent to Wigmore Primary School administering medicine in accordance with the Wigmore Primary School policy (Medicines in School 5.9c).

I will inform Wigmore Primary school immediately, in writing, if there is any change of dosage or frequency of the medication or if the medicine is stopped.

Parent's Signature:

Print name:

Date: