PARENTAL AGREEMENT FOR ARNETT HILLS SCHOOL TO ADMINISTER MEDICINE

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

Name of child	
Date of birth	
Class	
Medical condition/ illness	

MEDICINE

Name/ type of medicine *(as described on the container)*	
Date dispensed	
Expiry date	
Dosage and method	
Timing	
Special precautions	
Are there any side effects that the school needs to know about?	
Self administration	**Yes/ No** (delete as appropriate)
Procedures to take in an emergency	

CONTACT DETAILS

Name	
Daytime telephone number	
Relationship to child	
Address	

I understand that I must deliver the medicine personally to the school office
I understand that this is a service that the school is not obliged to undertake
I understand that I must notify the school of any changes in writing

Signed _____
Date _____