BEACONSFIELD HIGH SCHOOL

Parental agreement for school staff to administer pupil's own medicine.

Name of Pupil: ……..… Date of Birth: ….....

Medical condition or illness: …….

Name and strength of medication: ……..

Dosage and frequency: ……..……

Side effects (if any): ……..

Any other instructions: ……

MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY AND IT IS THE PARENT'S RESPONSIBILITY TO ENSURE THAT MEDICATION IS IN DATE.

Contact details

Name: ……..…

Main Contact No: ……..……..

Alternate Contact No: ……

I give consent for the school staff to administer medicine in accordance with the school policy and will notify the school of any changes in writing.

Signed: …… Date: …….