

FORM 3 – DAVISON C E HIGH SCHOOL FOR GIRLS

Parental agreement for school to administer medicine.

The school are unable to administer medication to your child unless you complete and sign this form:

Please return the form once completed to Student Services*.

NOTE: All medication needs to be in its prescribed box with pharmacy label attached and patient information leaflet inside as per WSCC guidelines.

DATE: _____

CHILD'S NAME: _____

DATE OF BIRTH: _____

CLASS/FORM: _____

MEDICAL CONDITION/ILLNESS: _____

NAME & STRENGTH OF MEDICINE: _____

EXPIRY DATE: _____

DOSAGE & METHOD: _____

WHEN TO BE GIVEN: _____

SPECIAL PRECAUTIONS/INSTRUCTION: _____

ANY OTHER INSTRUCTIONS: _____

SELF ADMINISTRATION _____ YES / NO [PLEASE DELETE AS APPROPRIATE]

NUMBER / QUANTITY OF TABLETS
TO BE GIVEN IN SCHOOL _____

DATE FOR REVIEW
[TO BE INITIATED BY MEMBER OF STAFF] _____

PARENT/CARER CONTACT DETAILS

NAME _____

ADDRESS _____

DAYTIME CONTACT NUMBER _____

RELATIONSHIP TO CHILD _____

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school staff administering medicine in accordance with the school policy. I will inform the school immediately in writing if there is any change in dosage or frequency of the medication or if the medicine is stopped.

PARENT/CARER SIGNATURE _____

PRINT NAME _____

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