

**FORM 3 - 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