Parental agreement for Hyde Park Infant School to administer medicine.

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

Name of school Hyde Park Infants School

Name of child ______________________________

Date of Birth ______________________________

Class ______________________________

Medical condition/illness

____

Medicine

Name of medicine	
Prescribed by	
Date prescribed	
Expiry date	
Dosage and method	
Number of days medication to be administered	
Time to be administered	12 noon
Any side effects that the school needs to be aware of	
Procedures to take in an emergency	

Contact Details

Name	
Daytime telephone No	
Mobile no.	
Relationship to child	

I understand that I must deliver the medicine personally to **Office Staff** and collect it from the **office** at the end of the school day. I accept 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.

Signature	Date