

THOMAS RUSSELL JUNIOR SCHOOL

Parental agreement for school to administer medicine

*The school will **not** give your child medicine unless you complete and sign this form,
This school has a policy that staff can administer medicine.*

Name of Child: _____ Class: _____

Medical condition/illness: _____

Medicine

Name/Type of Medicine
(as described on the container): _____

Storage instruction (eg: refrigeration): _____

Dosage and method: _____

Timing: _____

Special Precautions: _____

Are there any side effects that
school should know about? _____

Self Administration: Yes / No (delete as appropriate)

NB: Medicines must be named and in original containers as dispensed by the pharmacy

Contact Details

Name: _____ Daytime Telephone No: _____

I understand that I must deliver the medicine personally to the school office and 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(s): _____ Date: _____

Relationship to child: _____