MEDICAL FORM 1A

PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

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

ST. AUGUSTINE'S CATHOLIC PRIMARY SCHOOL

NAME OF CHILD ....

DATE OF BIRTH ....

CLASS ....

MEDICAL CONDITION OR ILLNESS ....

MEDICINE

NAME/TYPE OF MEDICINE (AS DESCRIBED ON THE CONTAINER) ....

DATE DISPENSED ....

EXPIRY DATE ....

DOSAGE AND METHOD ....

SPECIAL PRECAUTIONS ....

ARE THERE ANY SIDE EFFECTS THAT THE SCHOOL NEEDS TO KNOW? ....
....

PROCEDURES TO TAKE IN AN EMERGENCY ....

NOTE: MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY

CONTACT DETAILS

NAME & RELATIONSHIP TO CHILD ....

DAYTIME TELEPHONE NUMBER ....

ADDRESS ....
....

I UNDERSTAND THAT I MUST DELIVER THE MEDICINE PERSONALLY TO (staff member) ....

I accept that this is a service that the School is not obliged to undertake. I understand that I must give written notification to the School of any changes.

THE ABOVE INFORMATION IS, TO THE BEST OF MY KNOWLEDGE, ACCURATE AT THE TIME OF WRITING AND I GIVE CONSENT TO SCHOOL STAFF SUPERVISING THE ADMINISTRATION OF MEDICINE. 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.

Date .... Signature..
PLEASE PRINT NAME