Parental Agreement: Administration of Medication

1. Student Information:

Name: _____ Date of birth: _____

Year Group: _____ Form Group: _____

2. Administration of Medication

Name of medication: _____

Dosage: _____

When medication is to be taken: _____

Duration medication to be taken (if applicable): _____

Any other information: _____

Parent signature: _____ Date: _____

Print name: _____ Contact Number: _____

3. Medication Received – to be completed by school staff

Date medication provided by parent: _____

Quantity received: _____

Expiry date: _____

Staff signature: _____ Print name: _____

Quantity of medication returned to parent: _____

Date: _____

Staff signature: _____ Print name: _____