**FORM 3**

**Parental agreement for school/setting to administer medicine**

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

|  |  |
| --- | --- |
| Name of School/Setting  | Brychall High School  |
| Date |  |
| Young Person’s name |  |
| Class/Form |  |
| Medical condition or illness |  |
| Name/type of medicine (as described on container |  |
| Expiry date |  |
| Dosage (how much to give) |  |
| When to be given |  |
| Any other instructions |  |

***Note: Medicines must be in the original container as dispensed by the pharmacy***

**Contact Details**

|  |  |
| --- | --- |
| Name  |  |
| Daytime telephone number |  |
| Relationship to child/young person |  |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the

school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent’s signature

Print name Date