**Parental agreement for school to administer medicine**

***Note: medicine must be in the original container/box as dispensed by the pharmacy***

***The school will not give your child medication unless you complete and sign the form***

Name of School:

Marjory Kinnon School

Name of Child:

Reason for medication:

Name of medication:

Expiry date:

Signature of Staff member receiving medication ………………………………………………………………………………

Dose to be given

When to be given

Any known side effects

Is this medication**: prescribed by GP** **bought over the counter** (please circle)

**I understand that I must deliver the medication in the original box if prescribed by GP or in a sealed box/container if bought over the counter.**

Signature ……………………………………………………………………..

Print name ……………………………………………………………………

Date ……………………………………………………………………………..