GODSTONE PRIMARY AND NURSERY SCHOOL

Parental agreement for Godstone Primary & Nursery School to administer medicine

Name of Child …… **Date of Birth** …….……..

Class ……

Medical condition or illness …….

Name of medicine ……**Date started** ……

Number of day's medicine to be administered for ……**Dosage** …….

Time/s to be given .....

I understand that I must deliver the medicine personally to a member of the office staff. I accept that this is a service that the school is not obliged to undertake. I give consent to the school staff administering medicine in accordance with the school policy. 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.

Name ..... Relationship to child .....

Daytime telephone no. .....

Date…… Signature(s) ……

FOR OFFICE USE ONLY

Date/time administered/initial:-

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