**MEDICINE FORM**

**Parental agreement for Trewirgie Infants to administer medicine.**

**The school will not give your child medicine unless you complete & sign this form.**

Name of child ................................................................................................................

Date of birth ..................................................Class......................................................

Medical condition or illness...............................................................................................

**Medicine**

Name/type of medicine.........................................................Dosage ...............................

(As described on the container

Time to be given................................................................................................................

For how long will your child take this medication.............................................................

To be kept in fridge YES/NO

Use By Date......................................................................................................................

Special precautions...........................................................................................................

Are there any side effects the

School needs to be aware of.............................................................................................

**Contact details**

Name................................................. Contact telephone number....................................

Relationship to pupil..........................................................................................................

Date Signature

**I understand that I must deliver the medicine directly to the office, and accept that this is a service which the school is not obliged to undertake.**