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Middlesex
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Headteacher: Mr. M. Cramer, BA Hons, MA

Parental/Guardian Agreement for the School to Administer or Supervise Self- Administration of Medication.

The school will not authorise the administration of any medication unless a Parent/Guardian completes and signs this form.

Student Name _____ Form _____

Date of Birth _____

Medical Condition _____

Medication to be taken _____

Dosage/Instructions for administration/Storage_____

_____

Duration medicine to be taken _____

Expiry date of medication _____

EMERGENCY CONTACT DETAILS

Contact Name	Home Number	Work Number	Mobile Number

Name and Address of Doctor_____

_____

I understand that I must deliver the medication personally to Reception/Welfare Room.

Parent/Guardian Signature _____ Date _____