



Together we learn.  
Together we thrive.

**Linton Heights Junior School**

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## PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

**THE SCHOOL WILL NOT GIVE YOUR CHILD MEDICINE UNLESS  
YOU COMPLETE AND SIGN THIS FORM**

<b>DATE</b>	
<b>CHILD'S NAME</b>	
<b>NAME AND STRENGTH OF MEDICINE</b>	
<b>EXPIRY DATE</b>	
<b>HOW MUCH TO BE GIVEN (DOSE)</b>	
<b>WHEN TO BE GIVEN</b>	
<b>NUMBER OF TABLETS/QUANTITY GIVEN TO SCHOOL</b>	
<b>ANY OTHER INSTRUCTIONS</b>	

**NOTE: Medicines MUST be in the original container as dispensed by the pharmacy**

<b>NAME AND TELEPHONE NO. OF GP</b>	
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**The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school staff administering the above 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 medication is to be stopped.**

**Signature of Parent/Carer ..... Date .....**



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Awarded by Arts  
Council England

