



# Minet Junior School

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Headteacher: Ms K Ryan

Parental agreement for school to administer non-prescribed medicine

**CALPOL/CETIRIZINE**

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

Name of child:	
Date of birth:	
Class:	

## Medicine

Name (as printed on the container):	CALPOL/ CETIRIZINE
Expiry date:	EXPIRY DATE OF CALPOL/CETIRIZINE WILL BE CHECKED PRIOR TO ADMINISTRATION
Dosage and method:	AS PER INSTRUCTION LABEL IN ACCORDANCE WITH AGE GUIDELINES
Timing:	AS PER INSTRUCTION LABEL IN ACCORDANCE WITH AGE GUIDELINES

## Contact details of parent/carer

Name:	
Daytime contact number:	
Relationship to child:	

**I understand that the school holds a bottle of CALPOL/CETIRIZINE on site to be used for the purpose of pain relief, fever and various allergies. I give permission for the qualified staff to administer it in accordance with the above instructions. The school will call home before any medicine is given.**

Name:	Date:
Signature:	