PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

The school will not give your child medicine unless you complete and sign this form and the school has agreed that staff can administer medicine.

Child's name			
Date of birth			
Group/class/form			
Medical condition or illness			
Medicine Name/type of medicine *(as described on the container)*			
Date dispensed		Expiry date	
Agreed review date to be initiated by *(name of member of staff)*			
Dosage and method			
When to be given			
Special precautions			
Are there any side effects that the school needs to know about?			
Self administration	Yes/No *(delete as appropriate)*		

Procedures to take in an emergency	

Note: Medicines must be in the original container as dispensed by the pharmacy

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school administering medicine in accordance with the school arrangements. 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.

Contact Details:

Name	
Relationship to pupil	
☎ Daytime	
☎ Mobile	
Address	

Parents:

I understand that I must deliver the medicine personally to *(insert name of agreed member of staff here)* ___________________________________.

I accept that this is a service that the school is not obliged to undertake.

I understand that I must notify the school of any changes in writing.

Print Parent/Guardian Name:	Signature:
	Date:

Documentation completed by (health professional):

Name and designation:	Signature:
	Date:

If more than one medicine is to be given, a separate form should be completed for each one.