

**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 a policy that the staff can administer medicine.

Date for review to be initiated by	
Name	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine <i>(as described on the container)</i>			
Expiry date	day	month	year
Dosage and method			
Timing			
Special precautions/other instructions			
Are there any side effects that the school/setting needs to know about?			
Self-administration – y/n			
Procedures to take in an emergency			

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

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	Mrs Karen Saywood

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s)

Date