

Parental Agreement for School to Administer Medicine

The school / setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that allows staff to administer medicine.

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| --- | --- | --- | --- | --- |
| Name of school / setting |  | | | |
| Name of child |  | | | |
| Date of birth |  |  |  |  |
| Group / class / form |  | | | |
| Medical condition or illness |  | | | |
| Daily care requirements (e.g. before sport / lunchtime) |  | | | |
| Describe what constitutes an emergency for the child, and action to be taken should this occur |  | | | |

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| **Medicine** | **Note: Medicines must be in the original container as dispensed by the pharmacy** | | | |
| 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 |  | | | |
| Any other instructions |  | | | |
| Timing |  | | | |
| Special precautions: |  | | | |
| Has this medicine been administered to the child before and without any adverse side-effects? | Yes or No (circle as appropriate)  If ‘No’ please give details? | | | |
| Are there any side effects that the school / setting needs to know about? |  | | | |
| Self-administration |  | | | |
| Procedures to take in an emergency |  | | | |

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| **Contact Details** |  |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
| Who is the person to be contacted in an emergency (state if different for offsite activities) |  |
| Name and phone no. Of GP |  |
| I understand that I must deliver the medicine personally to | [agreed member of staff] |

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

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school / setting staff (or my son / daughter) administering medicine in accordance with the school / setting policy. I understand that I must notify the school / setting in writing of any change in dosage or frequency of medication or if medication is to be stopped being administered.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_