



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 staff can administer medicine.

Name of child

Date of birth

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 **Mrs T Jarman**

Dosage and method

Timing

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

Contact Details

Name

Daytime telephone number

Relationship to pupil

Address

I understand that I must deliver the medicine personally to Mrs T Jarman.

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.

Date..... Signature.....

If more than one medication, please use a separate sheet.