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.