



Parental agreement for school to administer medicine

The school will not give your child's medicine unless you complete and sign this form in accordance with the schools policy that staff can administer medicine

Name of School: \_\_\_\_\_

Name of Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Form: \_\_\_\_\_

Medical condition/illness/Allergies: \_\_\_\_\_

**Medicine**

Name 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: \_\_\_\_\_

Time: \_\_\_\_\_

Special Precautions/Previous Symptoms/Reactions (if applicable): \_\_\_\_\_

Side effects that the school needs to know about: \_\_\_\_\_

Self Administration: Yes/No (delete as applicable): \_\_\_\_\_

School to Administer: Yes/No (delete as applicable) \_\_\_\_\_

Please see overleaf →

**Procedures to take in an Emergency**

Contact Details: \_\_\_\_\_

Name: \_\_\_\_\_

Daytime Telephone No: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Address: \_\_\_\_\_

I understand that I must deliver the medicine personally to [agreed member of staff] and 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(s): \_\_\_\_\_

Relationship to student: \_\_\_\_\_

**Note: Medicines must be in the original container as dispensed by the pharmacy, collected at the end of each term and returned if required at the start of the next term**