



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 the staff can administer medicine.

Name of child	
D.O.B	
Class	
Medical condition or illness	

Medicine

Name/type of medicine (<i>as described on the container</i>)	
Expiry date	
Dosage method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting need 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	(agreed member of staff)

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.	
Daily care requirements	
Specific support for the pupil's educational, social and emotional needs	
Arrangements for school visits/trips etc.	
Other information	
Describe what constitutes an emergency, and the action to take if this occurs	
Who are main contacts:	1. Name Telephone 2. Name Telephone

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 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 _____

Print name _____

