PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER PRESCRIBED 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 School:		Class:	
Name of Child:			
Date of Birth:			
Medical condition or illness:			
Medicine			
Name/type of medicine (as described on the container)			
Date dispensed:		Expiry date:	
Dosage and method:		Long term medicine Y/N?	
When to be given:			
Are there any side effects that the school need to know about?			
Self administration?	Yes/no (delete as appropriate).		
Procedures to take in an emergency:			
Is there a "Care Plan" in place?	Yes/no (delete as appropriate)		
Contact Details			
Daytime telephone no:			
Name and phone no. of GP:			
Agreed review date to be initiated by name of member of staff			

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency or if the medication is stopped.

Name: …… Signature: ……

Relationship to the child …… Date: ……