Parental agreement for school to administer medicine

One form to be completed for each medicine.

The school will not give your child medicine unless this form is fully completed and signed.

Name of child _____Class _____

Date of Birth _____/_____/_____

Medical condition or illness _____

Medicine: To be in original container with label as dispensed by pharmacy

Name/type and strength of medicine
(as described on the container) _____

_____

Date dispensed _____/_____/_____

Expiry date _____/_____/_____

Dosage and method _____

Time to be given _____

Special precautions _____

Are there any side effects that the
school should know about? _____

Self-administration Yes/No (delete as appropriate)

Procedures to take in an emergency _____

Parent/Carer Contact Details:

Name _____

Daytime telephone no. _____

Relationship to child _____

Address _____

_____

I understand that I must deliver the medicine personally to a first aider.
The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to appropriately trained 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 of the medication or if the medicine is stopped.

Parent/Carer's signature _____

Date _____

Record of regular medicine administered to an individual child (Parts A and B)

Part A - Parent/Carer Authorisation

Name of child _____

Date of medicine provided by parent _____/_____/_____

Group/class/form _____

Name and strength of medicine _____

Dose and time medicine to be given_____

Staff signature _____

Signature of parent _____

Date _____

Quantity returned home and date _____

Confirmation of the Head's agreement for medication to be administered.

It is agreed that the child named above will receive the stated dose of medication.

Date _____

Signed _____

(**The Head teacher/Head of setting/Named Member of Staff**)

Part B - Records

Name of child _____

Name and strength of medicine _____

Dose and time medicine to be given * _____

***Check the medication given coincides with the information stated on Part A.**

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Name of member of staff			
Staff initials			