



## 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.

Please ask to see **Miss Hunt, Miss Critchley or Mrs Crawley**

Date for review to be initiated by	
Name of school/setting	
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

### Medicine

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

Signed (Parent)	
Signed (School)	