THIS FORM SHOULD ONLY BE USED FOR PRESCRIBED MEDICATION

Parental Agreement for School to Administer Medicine

The school will not give your child prescribed medicine unless you complete and sign this form.

Name of child Date of birth	
Tutor group	
Medicine	
Name/type of medicine	
(as described on the container)	
Expiry date	
How much to be given	
When to be given	
Any other instructions	

NB: Medicines must be in the original container as dispensed by the pharmacy.

Contact Details

Daytime telephone number of parent/carer or adult contact

Name and telephone number of GP

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the 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 medication is stopped.

Parent/carer signature: _____ Date: _____

Print name:

IF MORE THAN ONE MEDICINE IS TO BE GIVEN A SEPARATE FORM SHOULD BE COMPLETED FOR EACH ONE.