

**Parental agreement for setting 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.

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| 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 *(as described on the container)*  |   |
| 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  | [agreed 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/setting staff administering medicine in accordance with 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