

**Parental agreement for the 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 staff can administer medicine.

|  |  |
| --- | --- |
| Date for review to be initiated (if ongoing) |  |
| Name of child: |  |
| Date of Birth: |  |
| Class: |  |
| Medical Condition or illness |  |

**Medicine**

|  |  |
| --- | --- |
| Name/type of medicine :  (as described on 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? | Yes/No |
| 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 a change in dosage or frequency of the medication or of the medicine is stopped.

Signature: ………………………………………………………………….. Date: ………………………………..