

Parental agreement for school/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

Name of School/Setting Plympton St. Maurice Primary School

Name of Child: _____

Date of Birth: _____

Group/Class/Form: _____

Medical condition/illness: _____

Medicine

| | |
|--------------------------------------------------------------------------|--------------------------------|
| Name/Type/Quantity of Medicine (as described on the container): | |
| Date dispensed: | |
| Expiry date: | |
| Agreed review date to be initiated by <i>[name of member of staff]</i> : | |
| Dosage and method: | |
| Timing: | |
| Special Precautions: | |
| Are there any side effects that the school/setting needs to know about? | |
| Self Administration: | Yes/No (delete as appropriate) |
| Procedures to take in an Emergency: | |

Contact Details

| | |
|-----------------------------------------------|--|
| Name: | |
| Daytime Telephone No: | |
| Mobile No: | |
| E-mail (if appropriate as emergency contact): | |
| Relationship to Child: | |
| Address: | |

I understand that I must deliver the medicine personally to the school office and accept that this is a service that the school/setting is not obliged to undertake.

I understand that I must notify the school/setting of any changes in writing.

| | |
|------------------------|--|
| Date: | |
| Signature(s): | |
| | |
| Relationship to child: | |

Confirmation of the Head's agreement to administer medicine

| | |
|------------------------|--------------------------------------------|
| Name of School/Setting | Plympton St. Maurice Primary School |
|------------------------|--------------------------------------------|

It is agreed that _____ *[name of child]* will receive _____
[quantity and name of medicine] every day at _____ *[time medicine to be administered e.g. Lunchtime or afternoon break].*

_____ *[name of child]* will be given/supervised whilst he/she takes their medication by _____ *[name of member of staff].*

This arrangement will continue until _____ *[either end date of course of medicine or until instructed by parents].*

Date: _____

Signed: _____

[The Head teacher/Head of Setting/Named Member of Staff]

The school/setting will make every effort to provide this service; should any circumstances prevent the school/setting from doing so, the school/setting will inform the named contact at once, so that alternative arrangements can be made by the parent.