Appendix 3

Parental agreement for the administration of medicines

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

Date: _____ Childs Name _____

Age _____ Yr Group & Class _____ DOB _____

Condition / Illness _____

Name and Strength of Medicine _____

Where Medicine Kept : _____

Side Effects: _____

Expiry date: _____

How much (dose) to give: _____ Date of Provision _____

When to give it _____

Number of tablets given to school _____

Note : MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST. STUDENTS SHOULD NOT SELF ADMINISTER

Daytime contact number of parent or adult contact

_____

Name and contact number of GP

_____

Agreed review date _____

This information is, to the best of my knowledge, accurate at time of writing and I give consent to the school staff, to administer the 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 medicine is stopped.

Parent/Guardian signature _____

Print name _____

Date _____

Appendix 4

Headteacher agreement to administer medicine where a Risk Assessment or Health Care Plan are not needed (e.g. asthma)

It is agreed that _____ will receive _____
(Quantity and name of medicine)

Every day at _____

_____ (Name of child) will be given their medicine or supervised in taking it by

_____ (Name of member of staff)

This arrangement will continue until _____
(either end date or until instructed by parents)

Signed _____
(Headteacher / Head of setting / named member of staff)

Date: _____