



Agreement for School setting to administer medicine

Name of School	
Name of child	
Date of birth (dd/mm/yyyy)	
Medical condition or illness	

Medicine

Name/type of medicine (as described on the container)	
Date dispensed	
Expiry date	

Agreed review date to be initiated by

--	--

Dosage and method	
Timing	
Special precautions	
Are there any side effects that the school needs to know about?	
Self administration	Yes/No (delete as appropriate)
Procedures to take in an emergency	
Contact Details	
Name	
Daytime telephone no.	
Relationship to child	
Address	

- I understand that I must deliver the medicine personally to [agreed member of staff] and that Medicines should be in the same container as dispensed by the pharmacy.
- The above information is to the best of my knowledge accurate at the time of writing and I understand that I must notify the school of any changes in writing.

Date

Parent's
Signature(s)
