PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

Child's Name _____ **Date of birth** _____

Reason for Medicine _____

Name of Medicine _____

Expiry date of Medicine _____

Self-administration **Yes/No** **Storage requirements** **Fridge/non-fridge**

Period of treatment _____ **(max 5 school days)**

Possible Side effects _____

Special Requirements _____ **(e.g. take with food)**

School

Dosage _____ **Times*** _____ **Route** _____

After School Club

Dosage _____ **Times*** _____ **Route** _____

*School staff are NOT authorised to determine when an "as needed" medication is to be given, specific instructions are necessary

Parents are responsible for the delivery and collection of the medicine to/from the office. All medicines are to be collected at the end of each treatment period and must be clearly named with child's name in full, year group, contents, dosage and expiry date of medicine.

We will make every effort to give the prescribed dosage as requested on your behalf but can not be held responsible if, through circumstances, we omit to do so.

If it is essential that your child requires medication at a specific time, we request that parents make arrangements to do so themselves

I give permission for school staff to administer the medicine as described on this form.

I am aware that I must notify any changes to the school in writing

Signed (parent/carer) _____ Date _____

Day time Contact Number _____