

**Parental agreement for setting 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 the staff can administer medicine.

|  |  |
| --- | --- |
| Date  |  |
| Name of child |  |
| Date of birth |  |  |  |  |
| Group/class/form |  |
| Medical condition or illness |  |
| **Medicine** |  |
| Name/type of medicine*(as described on the 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.In most cases children will be encouraged to self-administer medication ie. apply creams. In a few cases, where agreed, staff will apply creams under the supervision of another member of staff.  |  |
|  |
| **NB: Medicines must be in the original container with the prescription label as dispensed by the pharmacy****Contact Details** |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
| Please give any additional information.  |  |

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 any change in dosage or frequency of the medication or if the medicine is stopped. I understand that I must deliver the medicine personally to the main office.

Signature(s) Date

Signature of Head Teacher or Senior Leader \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form must be kept in the Class Medical File – when medication is administered the staff member administering the medication must complete the Record of Medicine administered form which must also be stored in the Class Medical File.