



Parental agreement for school to administer medicine

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

The school has a policy that the staff can administer medicine.

Date for review to be initiated by	
Name of school	Kings Worthy Primary School
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	
Name/type of medicine <i>(as described on the container)</i>	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school needs to know about?	
Self-administration – y/n	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy with child's name & pharmacy contact details

Parent/Carer Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	A trained member of the school office staff

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering 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.

Signature(s) _____

Date _____

Please turn over and complete top section

Record of medicine administered to an individual child

PARENT TO COMPLETE

Name of school	Kings Worthy Primary School
Name of child	
Date medicine provided by parent	
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	
Quantity returned	
Dose and frequency of medicine	

Staff signature _____

Signature of parent _____

SCHOOL TO COMPLETE

Medicine					
Time given					
Dose given					
Member of staff					
Staff initials					

Medicine					
Time given					
Dose given					
Member of staff					
Staff initials					