Policy for the Administration of Medicines in Schools

Parental agreement for the administration of medicines

The school/setting will not give your child medicine unless you complete and sign this form and the school/setting has a policy that staff can administer medicine

Date: _____ Childs Name _____

School: _____

Age _____ Yr Group & Class _____ DOB _____

Condition / Illness _____

Name and Strength of Medicine _____

Where Medicine should be kept Kept : _____

Side Effects: _____

Expiry date: _____

How much (dose) to give: _____

When to give it _____

Quantity of medicine 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 _____