Parental Agreement for school/setting to administer medicine

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

Only medicines that have been prescribed shall be accepted and these shall be contained in their original container and include the prescriber's instructions for administration and dosage.

Name of child	
Date of birth	
Class	
Medical condition or illness	

Name / type of medicine (as described on the container)	
Date dispensed	
Expiry date	
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 number	
Relationship to child	
Address	

I understand that it is my responsibility to remind my child to go to the office to receive their medication. I also understand that this is a service that the school is not obliged to undertake. I will notify the school, in writing, of any changes to the above.

Signature_____ Date_____

St Peter's Junior School, Ruddington

Record of Administration of Medicine

Name of Child _____

Name of Medicine	Expiry Date	Date	Time Given	Dose Given	Name of Member of Staff	Staff Initials