

**Parental agreement for school to administer medication**

The school will only administer medicine if this form is fully completed and signed by a parent or carer with legal parental responsibility and where the administration of such medicine is within the remit of the school’s Supporting Pupils with Medical Conditions Policy.

Please note that where a medication has been prescribed to the child, this form needs to be completed once for the duration of the administration period. Where a medication has not been prescribed, this form needs to be completed for each day that the parent is requesting the medication to be administered.

**BASIC DETAILS**

|  |  |
| --- | --- |
| **Name of child** |  |
| **Date of birth** |  |
| **Class and year group** |  |
| **Medical condition or illness medicine is being used to treat** |  |

**MEDICINE**

|  |  |
| --- | --- |
| **Name/type of medicine (as described on the original container)** |  |
| **Prescribed or non-prescribed** |  |
| **Expiry date of medication** |  |
| **Start date for administration of medicine** |  |
| **End date for administration of medicine** |  |
| **Dosage and method** |  |
| **Timing of administration of medicine** |  |
| **Special precautions/other instructions** |  |
| **Has the child taken any of this medication already today?** *If so, please provide time and dosage.* |  |
| **Has the child ever had any medical reaction to this medication either recently or in the past?** *If so, please provide details.* |  |

**YOUR DETAILS**

|  |  |
| --- | --- |
| **Name of parent or carer completing form** |  |
| **Relationship to child** |  |
|  |  |
|  |  |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Southville Primary School staff to administer medicine in accordance with my instructions and the school’s policy. I will inform Southville Primary School immediately, in writing, if there is any change in dosage or frequency of the medication or the medication needs to stop being administered.

**Signed Parent/Carer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Day** | **Time** | **Dosage** | **Administered by** |
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