PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

Please note that the school will not administer medicine to your child unless you complete and sign this letter and the Headteacher has agreed that the school staff can administer the medication.

I request the administration of medicine to

Surname _____ First Name _____

Class _____ Date of Birth _____

Condition or illness _____

Name / Type of medication _____

Prescription ☐ Non-prescription ☐ (Please tick appropriate box)

Medication must be in the original container with the patient information leaflet included. Prescription medication must have the dispensing label attached.

Date Dispensed _____ Expiry Date _____

Dosage _____ Time required _____

Date start medication at school _____

Date end medication at school _____

Are there any side effects from the medication Yes ☐ No ☐

If yes, please give details on back of this form.

In the case of non-prescription medicines, i.e. Calpol, Piriton. I confirm that I have administered this medicine to my child before without adverse effect.
Ibuprofen and aspirin will <u>not</u> be administered unless they have been prescribed.

I understand that the medicine must be delivered personally to the school and that the school will only be able to administer the medicines if it can make the staff time available. I understand that I remain responsible for ensuring that my child receives medication and that I may have to make alternative arrangements for its administration if the school in unable to.

An adult must collect the medication from the school office every night. Any medicine left in school at the end of a working week, will be disposed of unless alternative arrangements have been made.

Signed by _____ Parent / Guardian