**Parental Agreement for Administration of Medicine in School**

Great Smeaton School Primary School has a policy that staff can administer medicine, HOWEVER, we will not give your child medicine unless you give permission by completing and signing this form.

|  |  |
| --- | --- |
| Name of Child  |  |
| Date of Birth  |  |
| Class  |  |
| Medical condition or illness  |  |

**Medicine**

|  |  |
| --- | --- |
| Name/type of medicine (as described on container)  |  |
| Expiry Date  |  |
| Dosage and Method  |  |
| Timing  |  |
| Special Precautions / other instructions  |  |
| Are there any side effects we need to know about?  |  |
| Self-administration Yes / No  |  |
| Procedures to take in an emergency  |  |

**NB Medicines must be in the original container as dispensed by the pharmacy**

|  |  |
| --- | --- |
| Name  |  |
| Daytime telephone number  |  |
| Relationship to Child  |  |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Record of Medication Administered in School** |
| **Date** | **Time**  | **Dose** | **Administered by** | **Witnessed by** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |