**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** |
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