Parental Agreement for School to Administer Medicine

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

Date for review to be initiated by	
Name of school/setting	Great Kingshill CE Combined School
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*		
Expiry date		
Dosage and method		
Timing		
Special precautions/other instructions		
Are there any side effects that the school/setting needs to know about?		
Self-administration – y/n		
Procedures to take in an emergency		
Prescription/Non-Prescription (Delete as appropriate)	Prescription	Non-prescription

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

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	*The office staff at Reception*

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school's policy.

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Prescribed Medication: 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. *(delete as appropriate)*

Non-prescription medication: I confirm that I have administered this non-prescription medication, without adverse effect, to my child in the past. I will inform the school immediately, in writing, if my child subsequently is adversely affected by the above medication. *(delete as appropriate)*

If more than one medicine is required a separate form should be completed for each one.

Signature(s) _____ Date _____