

PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE



Muskham Primary School will not give your child medicine unless you complete and sign this form.

Name of child	
Date of birth	
Class	
Date medicine provided by parent/carer	
Medical condition or illness	

Medicine

Name/type of medicine (as described on container)	
Dosage to be administered	
Time to be given	
Duration (please state final date to be administered)	
Expiry Date	
Are there any side effects that the school needs to know about?	
Procedures to take in an emergency	
Confirmation of receipt of medicine at school. Signed (Staff Member) Print Name	

NB: Medicines must be in the original container as dispensed by the pharmacy and clearly labelled with pupil's name and class. We will only administer prescribed antibiotics once a day.

Contact details

Name	
Daytime telephone number	
Relationship to child	
I understand that I must deliver the medicine personally to the school office and collect the medicine when finished.	Signed: Date:

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Muskham Primary School for their staff to administer 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: _____ Parent/Carer Date: ____ / ____ / ____

RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL

[illegible]