Agreement for School to administer NonPrescribed Medication

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

Please note that medication must be in the original container (with Patient Information leaflet enclosed)

PUPIL DETAILS

Surname: …… First Name: …….. Tutor Group: ……..

Address: ……..

……..

Condition / Illness: ……...

MEDICATION DETAILS

Name of medication (as described on container) ……..

Please specify how long your child will need to take this medication:

Short term: Dates From …….. To ……..

Ongoing: Start date: ……..

Date Medication bought: ……

Dosage to be administered: (as per label/instructions on medication) ……...

Time to be administered: ……

Special precautions/Possible side effects: ……...

Procedures to take in an emergency: ……..

CONTACT DETAILS

Name: ……..... Daytime Telephone Number: ……..

Relationship to child: ……

Address: ……..

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent for this medication to be administered to my child, in accordance with the above instructions and confirm that I have administered this medication in the past without adverse effect.

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.

Signed: …….. Date: ……

Please note that Parent/Carers are responsible for keeping medicines up-to-date, notifying school of any changes and renewal of out-of-date medication and returning to dispensing pharmacy.