

The school will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

| | |
|------------------------------------|--|
| Date for review to be initiated by | |
| Name of school | |
| Name of child | |
| Date of birth | |
| Year Group/class | |
| Medical condition or illness | |
| Quantity/Date received by parent | |
| Quantity/Date returned to parent | |

Medicine

| | |
|---|--|
| Name/type of medicine <i>(as described on the container)</i> | |
| 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 | |

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 | [agreed member of staff] |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Staff Signature(s) _____ Date _____

Parent Signature (s) _____ Date _____

Ensure you double check all details to the front of this sheet

