



## **Parental Agreement for School to Administer Medicine**

Dishforth C of E Primary School will not give your child medicine unless you complete and sign this form, and the school has a policy that the staff can administer medicine.

Date for review to be initiated by	
Name of school	Dishforth C of E Primary School
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

### **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	Mrs Joanne McBride, School Administrator

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.

Signature(s) \_\_\_\_\_

Date \_\_\_\_\_