

**Reculver CE Primary School**  
**Policy for the Administration of Medicines in Schools**  
**Appendix 3**

**Parental agreement for the administration of medicines**

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

Date: \_\_\_\_\_ Childs Name: \_\_\_\_\_

School: \_\_\_\_\_

Age: \_\_\_\_\_ Yr Group & Class: \_\_\_\_\_ DOB: \_\_\_\_\_

Condition / Illness: \_\_\_\_\_

Name and Strength of Medicine: \_\_\_\_\_

Where Medicine Kept: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Expiry date: \_\_\_\_\_

How much (dose) to give: \_\_\_\_\_ Date of Provision \_\_\_\_\_

When to give it: \_\_\_\_\_

Number of tablets given to school: \_\_\_\_\_

**Note : MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST. STUDENTS SHOULD NOT SELF ADMINISTER.**

---

Daytime contact number of parent or adult contact

\_\_\_\_\_

Name and contact number of GP

\_\_\_\_\_

Agreed review date

\_\_\_\_\_

This information is, to the best of my knowledge, accurate at time of writing and I give consent to the school / setting staff, to administer the 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.

Parent/Guardian signature \_\_\_\_\_

Print name \_\_\_\_\_

Date \_\_\_\_\_

---