Agreement to Administer Medicine **Coquet Park First School**

TO BE COMPLETED BY PARENT OR CARER AND RETURNED TO THE SCHOOL OFFICE WITH MEDICATION:

One form to be completed and signed for each type of medication

Name of school	Coquet Park First School
Name of child	
Year group	
Name and strength of medicine (One medication only. Additional form needed for additional medication)	
Date given to school	
Dose and frequency of medicine (or as printed dosage schedule) Times required	*For example : 1 X 5ml spoon at 1:05pm*
Quantity given to school (number/dose/volume) (May be an approximate volume based upon container)	
How is the medicine to be given? e.g as drops, by mouth, etc Will it require storage in a locked fridge?	
	Will the medication stay in school? yes / no or Will the medication be collected from school and returned on a daily basis? yes /no
End date for the course of medication	
Total number of school days required	

It is agreed that (*name of child)* ____________________________ will receive

(name & dosage of medicine) ____________________________________

At the following time/s _____________________________________

Review date (longer tem medication) _____________________________________

Signature of parent/carer _________________________ Date: ____________

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TO BE FILLED IN BY SCHOOL STAFF

Checklist before medication is taken from parents or carers:

Medicine within the original container	
Medicine clearly labelled with the pupils name	
Medicine in date	
Medication start and end dates recorded	
Parents/ carers informed they will be contacted should there be any queries. Contact number recorded at school	
One form filled in for each type of medication. Multiple copies stapled together	
Complete form filled in and signed (two sided)	

Medicine received in school by: __________________________ date: _______________

Signature (Headteacher or Deputy Head) In their absence an experienced teacher in school:

Name: ____________________________ Date: ____________