



PARENTAL/HEADTEACHER AGREEMENT FOR SCHOOL/SETTING TO ADMINISTER MEDICINE

The school/setting will not give your child medicine unless you complete and Sign this form.

Name of School/Setting	
Date	
Childs Name	
Class	
Medical Condition or illness	
Name and Strength of medicine	
Expiry Date	
How much to be given (Dose to be given)	
When to be given	
Duration in which medicine is to be given	
Any other instructions	
Number of tablets/quantity to be given to school/setting	
Any possible side effects	

Medicines must be in the original container as dispensed by the Pharmacy.

Contact Name	
Contact Phone Number	
Name of GP	
Phone Number of GP	

Agreed Review Date	
Name of member of Staff to Review	

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. 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.

Parents Signature	
Print Name	
Date	

