ALDERSBROOK PRIMARY SCHOOL
Let's learn together...

Parental Agreement Form for Self Administration and School Administration of prescribed Medication

The school **will not** give your child medicine unless you complete and sign this form. ***Authorisation must be given by the Headteacher or member of the Senior Leadership Team.***

Name of child: ____________________ Date of Birth: ________

Class: ___ Medical Condition/Illness: _____________________

Medicine

Name of medicine: ____

Dosage and Method: ____

Times to be given: ______________________

Special Precautions: ____

Number of tablets/quantity to be given to school _____________________

End date of medicine/details of course of medication:

____

NOTE: The school will only accept medicines that have prescribed by a doctor. Medicines must be in the original container as dispensed by the pharmacy. The Pharmacists details must be clearly visible

Self Administered by child Yes No (Circle)

Administered by _________________________

Please turn over

Daytime phone number of parent or adult ____________________

Name and phone number of GP ____________________________

Note: I agree to inform the school, via the office, whenever my child takes medication before school.

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

Signed ________________ (Parent) Date __________

<u>For the School</u>

To be completed by Head teacher/Member of the Senior Leadership Team

It is agreed that __________________________ (name of child) will

receive _______________________________ (quantity and name of

medicine) every day at ______________________________ (time

medicine is to be administered). This arrangement will continue until

___________________________________ (either end date of the

course of medicine or instructed by parents)

Signed __________________________ Date ________________