

**Parental Agreement for School to Administer Medicines**

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

Date for review to be initiated by \_\_\_\_\_  
 Name of school setting \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Group/Class/Form \_\_\_\_\_  
 Medical condition or illness \_\_\_\_\_

**Medicine**

Name/type of medicine (*as described on the container*) \_\_\_\_\_  
 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                     *[agreed member of staff]*                    

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 \_\_\_\_\_  
 Date \_\_\_\_\_

**Record of Medicine Administered to an Individual Child**

|                                  |  |
|----------------------------------|--|
| Name of school setting           |  |
| Name of child                    |  |
| Date medicine provided by parent |  |
| Group/Class/Form                 |  |
| Quantity received                |  |
| Name and strength of medicine    |  |
| Expiry date                      |  |
| Quantity returned                |  |
| Dose and frequency of medicine   |  |

Staff signature \_\_\_\_\_

Signature of parent \_\_\_\_\_

|                         |  |  |  |
|-------------------------|--|--|--|
| Date                    |  |  |  |
| Time given              |  |  |  |
| Dose given              |  |  |  |
| Name of member of staff |  |  |  |
| Staff initials          |  |  |  |

|                         |  |  |  |
|-------------------------|--|--|--|
| Date                    |  |  |  |
| Time given              |  |  |  |
| Dose given              |  |  |  |
| Name of member of staff |  |  |  |
| Staff initials          |  |  |  |

|                         |  |  |  |
|-------------------------|--|--|--|
| Date                    |  |  |  |
| Time given              |  |  |  |
| Dose given              |  |  |  |
| Name of member of staff |  |  |  |
| Staff initials          |  |  |  |

|                         |  |  |  |
|-------------------------|--|--|--|
| Date                    |  |  |  |
| Time given              |  |  |  |
| Dose given              |  |  |  |
| Name of member of staff |  |  |  |
| Staff initials          |  |  |  |

**Record of medicine administered to an individual child  
(Continued)**

|                         |                      |                      |                      |
|-------------------------|----------------------|----------------------|----------------------|
| Date                    | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Time given              | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Dose given              | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Name of member of staff | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Staff initials          | <input type="text"/> | <input type="text"/> | <input type="text"/> |

|                         |                      |                      |                      |
|-------------------------|----------------------|----------------------|----------------------|
| Date                    | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Time given              | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Dose given              | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Name of member of staff | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Staff initials          | <input type="text"/> | <input type="text"/> | <input type="text"/> |

**Staff Training Record – Administration of Medicines**

|                            |                      |
|----------------------------|----------------------|
| Name of school setting     | <input type="text"/> |
| Name                       | <input type="text"/> |
| Type of training received  | <input type="text"/> |
| Date of training completed | <input type="text"/> |
| Training provided by       | <input type="text"/> |
| Profession and title       | <input type="text"/> |

I confirm that *[name of member of staff]* has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated *[name of member of staff]*.

|                     |                      |
|---------------------|----------------------|
| Trainer's signature | <input type="text"/> |
| Date                | <input type="text"/> |

I confirm that I have received the training detailed above.

|                       |                      |
|-----------------------|----------------------|
| Staff signature       | <input type="text"/> |
| Date                  | <input type="text"/> |
| Suggested review date | <input type="text"/> |