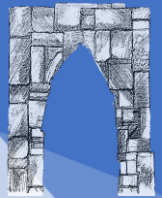


Priory Primary School

Achieving our best; supporting and celebrating each other.



Parental agreement for setting to administer medicine

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

Name of school	Priory Primary School
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine <i>(as described on the container)</i>	
Expiry date	
Dosage and method	
Timing	
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	
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 staff administering medicine in accordance with the school policy.

Signature(s) _____

Date _____

Priory Primary School

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Form Continued

Date	/ /	/ /	/ /
Time given			
Dose given			
Staff member name			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Staff member name			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Staff member name			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Staff member name			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Staff member name			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Staff member name			
Staff initials			