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St Joseph's
Catholic Academy

'Christ Be Our Light'

PARENTAL AGREEMENT TO ADMINISTER MEDICINE

Trust schools 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	St Joseph's Catholic Academy
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	Mrs Hart, Mrs Billing or Miss Harrison

A Member Of Bishop Hogarth Catholic Education Trust

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, followed in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s)_____ Date _____

RECORD OF MEDICINE ADMINISTERED

Name of school	St Joseph's Catholic Academy
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 /Carer _____

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			