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Parental Agreement for Administering Medicine

The school/setting 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.

School	St Nicholas School		
Name of child			
Date of birth		Gender	
Year Group		Reg Group	

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Medical condition or diagnosis	Summary	Notes

Medicine	
Name & strength of medicine <i>(as described on the container)</i>	
Expiry date	
Dose (amount) to be taken and method	
Time to be taken in school	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – y/n	
Please list any allergies your child has	

NB: Medicines must be in the original container as dispensed by the pharmacy

Family Contact Information	
Name	
Daytime telephone no.	
Relationship to child	
Address	

By signing this form I hereby give consent for trained and competency assessed staff to administer the medicines stated on the reverse to the named child. This will be done at the designated times, and as per the directions specified by the prescriber. I agree that medication will be administered in accordance with the school's policy.
I agree to inform trained school staff in the child's class **immediately** in writing if there are any changes to the medication, regime or if the medicine has been paused or stopped.
I understand that not sending in the named child's medication as per the requirements, or not providing up to date information or paperwork, may result in medication not be given.
I consent for school and NHS staff to access medical records for the named child if it is in their best interests to do so.
I declare that the information I have written is, to the best of my knowledge, accurate at the time of writing and signing this form

Signature(s) _____

Date _____