# Parental agreement for setting to administer medicine

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

| | |
|---|---|
| Date for review to be initiated by | |
| Name of Academy/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 academy/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] |
| I understand that I must deliver the Medicine to the academy office | |

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

Date _____

Review date _____

Parent's Signature

HeadTeacher's signature_____Date_____

This will be reviewed at least annually or earlier if the child's needs change