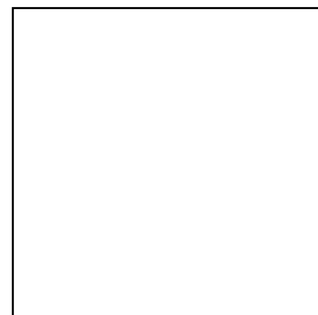
Administration of Medicines in School – Appendix 4

Section 1 - Parental agreement for the administration of medicines

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



Name of child:_______________________________________

Class:______________ Date of Birth: _______/_______/_______

School: **LADY BOSWELL'S C.E. PRIMARY SCHOOL**

Name & Strength of medicine:____

Dose and frequency of medicine :________________________

When to give it:____ Review Date ____________

Side Effects:____

Date medicine provided	Quantity received	Expiry date

Note: MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST. STUDENTS SHOULD NOT SELF ADMINISTER. ALL MEDICINES WILL BE KEPT IN MEDICAL ROOM

Daytime contact number of parent or adult contact______________________________________

Name & number of GP____

My child attends the Orchard After School Club on the following afternoons:

Monday	Tuesday	Wednesday	Thursday	Friday

(*Please tick appropriate days)*

This information is, to the best of my knowledge, accurate at time of writing and I give consent to the school staff to administer the medicine in accordance with the school policy. I will inform the school immediately in writing if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent/Guardian signature: _______________________________________ Date: ____________

Section 2 – Record of medicines administered to an individual child

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			