Horsford C of E VA Primary School

Parental Agreement for School Staff to Administer Medicine

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

DATE OF REVIEW TO BE INITIATED	
NAME OF SCHOOL	**HORSFORD PRIMARY SCHOOL**
NAME OF CHILD	
DATE OF BIRTH	
CLASS	
MEDICAL ILLNESS OR CONDITION	

MEDICINE	
NAME/TYPE OF MEDICINE AS DESCRIBED ON THE CONTAINER	
EXPIRY DATE	
DOSAGE AND METHOD	
TIMING	
SPECIAL PRECAUTIONS OR INSTRUCTIONS	
ARE THERE ANY SIDE EFFECTS WE NEED TO KNOW ABOUT?	
SELF ADMINISTRATION YES OR NO	
PROCEDURES TO TAKE IN AN EMERGENCY	

NB: MEDICINES MUST BE IN THEIR ORIGONAL CONTAINER AND DISPENSED BY A PHARMACY AND BE CLEARLY LABELLED WITH THE CHILDS NAME AND DOSAGE

CONTACT DETAILS	
NAME	
DAYTIME TELEPHONE NUMBER	
RELATIONSHIP TO CHILD	
ADDRESS	
I UNDERSTAND THAT I MUST DELIVER THE MEDICINE DIRECTLY TO	**MS EMMA CHAMBERS**

The above information is correct 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. I will inform the school immediately, in writing if there is any change in dosage or frequency of the medication or if this is stopped completely.

…….Signature of Parent

…….Date