



THE ASPIRE FEDERATION
of
Primary School's Procedure for the Administration of Medicines in Schools

Parental Agreement for the Administration of Medicines

The school/setting will not give your child medicine unless you complete and sign this form in order for the school/setting to adhere to a procedure that staff can administer medicines to your child.

Date: _____ Print Child's Name: _____

School: _____

Age: _____ Year Group and Class: _____ Date of Birth: _____

Condition/illness: _____

Names and Strength of Medicine: _____

Medicine to be kept in: _____

Potential Side Effects: _____

Expiry Date: _____

Dosage to be given: _____ Date of Provision: _____

When to give it: _____

Number of tablets given to school: _____

**Note: MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST
STUDENTS MUST NOT SELF-ADMINISTER**

Daytime telephone contact number of parent/guardian: _____

Name and contact number of GP: _____

Agreed review date: _____

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

Signed: _____ Parent/Guardian

Print Name: _____ Parent/Guardian

Date: _____