Parental Agreement for Deighton Gates Primary School to Administer Medicine

The information is, to the best of my knowledge, accurate at the time of writing and I give consent to Deighton Gates Primary School to administer 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. I understand that I must deliver the medicine personally to a member of staff in the school office and accept that this is a service that Deighton Gates Primary School is not obliged to undertake.

Name of School	Deighton Gates Primary School
Name of Child:	
Date of Birth:	
Group/Class/Form:	
Medical condition/illness:	
Name and phone no. of GP	

Medicine

Name/Type of Medicine (as described on the container):	
Date dispensed:	
Expiry date:	
Agreed review date to be initiated by a member of staff	
Dosage and method (before or after food)	
Number of tablets given to school if applicable	
Time Medicine to be Administered	11 am – 12 noon ☐ or 1.15 pm – 1.30 pm ☐
Special Precautions:	
Are there any side effects that the school needs to know about?	
Self Administration:	Yes/No (delete as appropriate)
Procedures to take in an Emergency:	

Contact Details

Name:	
Daytime Telephone No:	
Relationship to Pupil:	
Address:	
Date:	
Signature	

If more than one medicine is to be given a separate form should be completed for each one.

Record of Medicine administered to an individual pupil

Name of School	Deighton Gates Primary
Name of pupil	
Class	
Name and strength of medicine	
Expiry Date	
Dose and Frequency of Medication	
Staff Signature	

Date			
Time Given			
Dose Given			
Name of staff member			
Staff initials			

Date			
Time Given			
Dose Given			
Name of staff member			
Staff initials			