PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

The school will not give your child medicine unless you complete and sign this form. Please note that only medicine prescribed by your GP can be administered or supervised by staff.

Name of School	**Cropwell Bishop Primary School**
Name of Child	
Date of Birth	
Class	
Medical condition or illness	
Known allergies	
Medicine:	
Dr's name and telephone number	
Name and type of medicine (as described on the container/information sheet)	
Batch number	
Expiry date	
Date dispensed	
Date and time of last dose	
Dosage and method of administration	
Start date & time of administration	Date: Time:
End date of administration	Date:
Special precautions	
Are there any side effects that the school/setting needs to know about?	
Procedures to take in an emergency	
Parent/carer contact details:	
Name	
Daytime telephone number	
Relationship to child	
Address	

I give consent for a member of staff to administer the above drug/medicine. I understand that the drug/medicine may be administered by a different member of staff daily and that no staff members are qualified medical practitioners. (It is not the responsibility of the school staff to ensure that the drug/medicine is taken).
I undertake to deliver the correct medication to the school office in a childproof container/bottle, clearly labelled with my child's name, which will then be administered following the above instructions.
I understand that the school staff will take reasonable care in the administration of medicines in school and will endeavour to respond appropriately in all circumstances should emergency treatment be required.

Date …….. Signature(s)…….