Agreement for School to Administer Medicine

The school will not give your child medicine unless you complete and sign this form

Name of School	
Name of Child	
Date of Birth	
Medical Condition or Illness	
Date medicine provided by parent	
Group/Class	
Name and strength of medicine	
Dose and frequency of medicine	
Expiry date	
Special precautions/other instructions	
Self-administration – y/n	

NB: Medicines must be in the original container as dispensed by the pharmacy

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. 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.

Signature of Parent/Carer:…… Date:……...

Record of Medicine Administered to a Child (Continues overleaf)

Date			
Time given			
Dose given			
Name of member of staff administering			
Witness staff initials			

Date			
Time given			
Dose given			
Name of member of staff administering			
Witness staff initials			

Continued …			
Date			
Time given			
Dose given			
Name of member of staff administering			
Witness staff initials			

Date			
Time given			
Dose given			
Name of member of staff administering			
Witness staff initials			

Date			
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Dose given			
Name of member of staff administering			
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