|  |  |
| --- | --- |
| **PARENTAL AGREEMENT FOR TO ADMINISTER MEDICINE** | |
| Date for review to be initiated by |  |
| Name of Academy/setting |  |
| Name of child |  |
| Date of birth |  |
| Group/class/form |  |
| Medical condition or illness |  |
| **Medicine** |  |
| Name/type of medicine  (as described on the container) |  |
| Expiry date |  |
| Dosage and method |  |
| Timing |  |
| Special precautions/other instructions |  |
| Are there any side effects that the Academy/setting needs to know about? |  |
| Self-administration – y/n |  |
| Procedures to take in an emergency |  |
| **NB: Medicines must be in the original container as dispensed by the pharmacy**  **Contact Details** | |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |

I understand that I must deliver and collect the medicine personally to the school office.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Academy/setting staff administering medicine in accordance with the Academy/setting policy. I will inform the Academy/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s): Date:

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL CHILD** | | | | | | | | | |
| Childs Name: ……………………………………………. Class:………………………………………. | | | | | | | | | |
| Date |  |  |  |  |  |  |  |  |  |
| Time given |  | | |  | | |  | | |
| Dose given |  | | |  | | |  | | |
| Name of member of staff |  | | |  | | |  | | |
| Staff initials |  | | |  | | |  | | |
|  |  | | |  | | |  | | |
| Date |  |  |  |  |  |  |  |  |  |
| Time given |  | | |  | | |  | | |
| Dose given |  | | |  | | |  | | |
| Name of member of staff |  | | |  | | |  | | |
| Staff initials |  | | |  | | |  | | |