# Parental Agreement for setting to Administer Medicine

Broad Square Primary School will not give your child medicine unless you complete and sign this form.

| | |
|---|---|
| Date for review to be initiated by | |
| Name of school/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 school/setting needs to know about? | |
| Self-administration – y/n | |
| Procedures to take in an emergency | |

**NB: Medicines <u>must</u> 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 the medicine personally to | (agreed member of staff) |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering 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.

Signature(s)_____ Date_____