PARENTAL AGREEMENT TO ADMINISTER PRESCRIBED MEDICATION

CHILD'S NAME	
CLASS	
MEDICAL CONDITION/ILLNESS	
MEDICINE PRESCRIBED	
DOSAGE AND METHOD	
WHEN TO BE GIVEN	
SELF-ADMINISTRATION? YES	YES / NO
CARE PLAN IN PLACE?	YES / NO
PARENT CONTACT DETAILS	
NAME OF GP	

I give consent to school staff to administer medication in accordance with the school policy. I will inform the school immediately if there is any change in dosage or frequency, or if the medication is stopped.

Parents signature: ……..

Print name: …….. Date:……..

Please note that we are only able to administer medication that has been prescribed by your GP and will only administer antibiotics if required 4 times daily.

Please note that cough sweets (e.g. Lockets/Tunes are not allowed in school.