PARENTAL AGREEMENT FOR SHORT TERM MEDICATION TO BE GIVEN IN SCHOOL

NAME OF CHILD/YOUNG PERSON	
DATE OF BIRTH	
CONTACT INFORMATION OF PARENT/CARER	
GP	

Details of why medicine is needed

Does your child have any allergies? Yes/No
(If YES give details)

Medication to be given:

Name of Medication	Dose	Time to be given	Special Instructions (e.g. How to give it)

All medication must be sent to school in the original container.
Prescription label must be present and legible.
Any medication no longer required will be returned home for disposal

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Nursing/School staff administering medicine in accordance with the NHS/Education policies.

I will inform the School and School Nurse immediately, in writing or via email, if there is any change in the dosage or frequency of the medication or if the medication is stopped.

PARENT/CARER SIGNATURE:

PRINT NAME:

DATE: