**Parental agreement for school to administer medicines**

The school will not give your child medicine unless you complete and sign this form, and the school has a policy that the staff can administer medicine.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of school | 1. Sir John Hunt Community Sports College | | | |
| Name of child |  | | | |
| Date of birth |  |  |  |  |
| Medical condition or illness |  | | | |
|  |
| **Medicine** |  | | | |
| Name/type of medicine  *(as described on the container)* |  | | | |
| Expiry date |  |  |  |  |
| Dosage, method and Timing |  | | | |
| Special precautions/other instructions  (e.g) storage) |  | | | |
| 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 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 the medicine personally to | 1. [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