



Stretham Primary School

Parental Agreement to Administer Medicine

Stretham Community Primary School will not give your child prescribed medication unless you complete and sign this form.

Date for review to be initiated by

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?

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

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 _____