Parental Agreement for Lambs Lane Primary School to Administer Medicine



It is not possible for us to give your child medicine unless you complete and sign this form.

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| --- | --- |
| Name of child |  |
| Date of birth |  |
| Group/ Class |  |
| Medical Condition or Illness |  |
| **Medicine:** | NB Medicines must be in the original container as dispensed by the pharmacy |
| Name/ type of medicine (as described on the container): |  |
| Expiry Date |  |
| Administration instructions, including dosage, timings and special precautions |  |
| Are there any side effects that the school/setting needs to know about? |  |
| Does your child take it themselves? If they do is supervision needed? |  |
| Procedures to take in an emergency |  |
| Storage instructions |  medicine cabinet fridge |
| **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/setting staff administering medicine in accordance with the school/ setting policy. I will inform the school / setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature (s) Date

Record of medicine administered to an individual pupil.



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| --- | --- | --- | --- |
| Date | Time Given |  Dosage Given | Administered by: |
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Any comments: medication replaced, adverse reactions, observations, etc [dated]