**CARRINGTON JUNIOR SCHOOL**

**PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER PRESCRIBED MEDICINE**

|  |  |
| --- | --- |
| Date for review to be initiated by |  |
| Name of child |  |
| Date of birth |  |  |  |  |
| Class |  |
| Medical condition or illness |  |
| **Medicine** |  |
| Name/type of medicine*(as described on the container)* |  |
| Expiry date |  |  |  |  |
| Dosage and method |  |
| Timing |  |
| For how long will this medicine be administered |  |
| Special precautions/other instructions |  |
| Are there any side effects that the school 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 with the prescription label attached.****Contact Details** |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
| I understand that I must deliver the medicine personally to | A member of the admin 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’s policy.

 *Please turn over…*

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

# CARRINGTON JUNIOR SCHOOL

**CONFIRMATION OF THE HEADTEACHER’S AGREEMENT TO ADMINISTER MEDICINE**

It is agreed that **……………………………………………..** (*name of pupil)* will receive **……………………………………………………………** (*quantity and name of medicine)* every day at **…………………………** (*time medicine to be administered e.g. Lunchtime)*.

**……………………………………….……** (*name of pupil)* will be given/supervised whilst he/she takes their medication by a member of staff.

This arrangement will continue until **………………………..…** (*either end date of course of medicine or until instructed by parents).*

|  |  |
| --- | --- |
| Date:  |  |
| Signed:  |   |
|  *Headteacher* |
|  |
|  |