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

|  |  |
| --- | --- |
| Date for review to be initiated by |  |
| Name of school / setting |  |
| 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 of administration |  |
| Timing |  |
| Special precautions / other instructions |  |
| Are there any side effects that the school / setting needs to know about? |  |
| Self-administration – y/n |  |
| Procedures to be taken in an emergency |  |

**Nb. Medicines must be brought 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  | [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 / 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.

Parent Signature(s) Date

Head Teacher Signature(s) Date