



St Paul's CE Primary School

Parental agreement for school to administer medicine

Name of school

St Paul's CE Primary School

Name of child

Date of birth

Year group

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
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 number

Relationship to child

Address

I understand that I must deliver the medicine
personally to:

Miss K Harrison

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent for St Paul's Primary School staff to administering medicine in accordance with the school's 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: _____

Date		Date	
Time		Time	
Dosage		Dosage	
Staff Signature		Staff Signature	
Date		Date	
Time		Time	
Dosage		Dosage	
Staff Signature		Staff Signature	
Date		Date	
Time		Time	
Dosage		Dosage	
Staff Signature		Staff Signature	
Date		Date	
Time		Time	
Dosage		Dosage	
Staff Signature		Staff Signature	
Date		Date	
Time		Time	
Dosage		Dosage	
Staff Signature		Staff Signature	