

FORM 3: PARENT/CARER AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

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

| | |
|---|---------------------------------------|
| Name of school | Archbishop of York's CE Junior School |
| Name of child | |
| Date of birth | |
| Group/class/form | |
| Medical condition or illness | |
| Name/type of medicine (as described on the container) | |
| Quantity received (eg half bottle) | |
| Dosage and method: | |
| Timing: | |
| Special precautions / Storage details: | |
| Date dispensed: | |
| Expiry date: | |
| Are there any side effects that the school/setting needs to know about? | |
| Procedures to take in an emergency: | |
| Self administration: | |
| Planned review date: | |
| Person to initiate review: | |

Form 3 Continued/

FORM 3: PARENT/CARER AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE (continued)

PARENT/CARER CONTACT DETAILS

| | |
|------------------------|--|
| Name: | |
| Daytime telephone no. | |
| Relationship to child: | |
| Address: | |

I will deliver the medicines personally to

OR

I have school permission for my son/daughter to carry their own medicine to school

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

Parent/carer's name

Print signature

Date

SURPLUS/UNUSED MEDICINES:

The following quantity of the above medicine was collected by:

Name

Signature

Date

OR

The above medicine was not collected. It was taken to Chemist for safe disposal.

Name

Signature

Date