Parental agreement for Hadleigh Community Primary School to administer prescribed medication only

The school will not give your child any prescribed medication unless you complete and sign this form.

Date for review to be initiated by	
Name of school	Hadleigh Community Primary School
Name of child	
Date of birth	
Class	
Medical condition or illness	

Prescribed Medicine

Name/type of medicine *(as described on the container)*	

NB: Medicines must be in the original container as dispensed by the pharmacy

Start Date	
End Date	
Dosage and method	
Where to store medication	
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	

Contact Details	
Name	
Daytime telephone number	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	A member of the Office Staff

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school administering prescribed medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the prescribed medication or if the medicine is stopped.

I consent to this information being shared with any relevant school staff which may also include midday supervisors and if appropriate extended school staff.

Signature ______________________ Date ______________________

For Office Use Only:

Information recorded:

Office Whiteboard	
Teacher Register	