

Parental agreement for school to administer medication

Please complete this form in full if you require the school to administer medication to your child.

Child's Details

Full Name of Child: _____

Date of Birth: _____ Class / Year Group: _____

Medication Details

Name of Medicine: _____

Reason for Medication: _____

Dosage (amount to be given): _____

Method (e.g. oral, inhaler, topical): _____

Time(s) to be Administered: _____

Start Date: _____ End Date (if applicable): _____

Details of any known side effects: _____

Type of Medication

- ☐ Short-term (e.g. antibiotics)
- ☐ Long-term (e.g. daily management of condition)
- ☐ Ad hoc / as required (e.g. pain relief, inhaler)

Child's Doctor / Medical Professional

GP / Practice Name: _____

Practice Address: _____

Telephone Number: _____

Parental agreement for school to administer medication

Parent / Carer Contact Details

Full Name of Parent / Carer: _____

Relationship to Child: _____

Contact Number (Daytime): _____

Emergency Contact Number: _____

Email Address (if applicable): _____

Consent and Declaration

I confirm that the above information is correct and that I give consent for school staff to administer medication to my child as detailed above. I understand that:

- Medication must be provided in its original container, clearly labelled with the child's name, dosage instructions, and expiry date.
- It is my responsibility to ensure that the medication is delivered to and collected from school as required.
- The school cannot be held responsible for any adverse reaction to medication given in accordance with these written instructions.

Signature of Parent / Carer: _____

Date: _____

For School Use Only

Received by (staff name): _____

Date Received: _____

Storage Location: _____