Agreement for school to administer prescribed medication

Pupil Details:

Name of Pupil	
Date of birth	
Class and year group	
Medical condition	

Medication details:

Name of medicine (as described on container)	
Date dispensed	
Expiry Date	

Administration:

Date/s to be administered	
Dosage and method	
Timing	
Special precautions	
Side effects	
Procedures in an emergency	

- I understand that I must deliver the prescribed medicine personally to a member of staff and that the medicine should be in the same container as dispensed by the pharmacy, clearly displaying the dosage instructions
- The above information is to the best of my knowledge accurate at time of writing and I understand that I must notify the school of any changes in writing
- I have read and understood the school's policy on the administration of medicines
- I, the undersigned, consent to the administration of the prescribed medicine as detailed above:

Parent/legal guardian's name (print) _____

Parent/legal guardian's signature _____ Date: _____

For office use only

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For Office use only			
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