St Peter's
Church of England (Aided) Primary School

PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER PRESCRIBED MEDICINE

Medicines must be in the original container as dispensed by the pharmacy. The school will not give your child medicine unless you complete, sign and return this form

DATE					
CHILD's NAME					
CLASS					
MEDICAL CONDITION / ILLNESS					
NAME OF MEDICINE					
EXPIRY DATE					
DOSAGE REQUIRED TO BE GIVEN					
AT WHAT TIME					
ON WHICH DAYS (please circle)	MON	TUE	WED	THUR	FRI
TIME OF PREVIOUS DOSAGE (if taken)					
ARE THERE ANY POSSIBLE SIDE EFFECTS?					
CAN YOUR CHILD SELF-ADMINISTER?					
PROCEDURE TO TAKE IN AN EMERGENCY					
CONTACT DETAILS	Name:				
	Daytime contact no.:				
	Relationship to child:				

I request that the treatment noted above be given by a trained first aid member of staff. I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on school premises.

I confirm that this medicine has already been taken with no adverse reaction by my child, and will inform you immediately of any changes to the above. I accept that it is my responsibility to ensure that any medicines supplied are within their expiry date, and should they expire will provide the school with a replacement, as necessary.

I accept that whilst my child is in the care of the School, the school staff stand in the position of the parent and that the School staff may, therefore, need to arrange any medical aid considered necessary in an emergency and that I will be told of any such action as soon as possible.

I understand that whilst school staff will use their best endeavours to carry out these arrangements, no legal liability can be accepted by the School staff, Governors or the Local Education Authority in the event of any failure to do so, or of any adverse reaction by my child following the administration of the medicine/tablets.

Signed: …….. (Parent / Carer) Date: ……