Parental Agreement for St John's School Staff to Administer Medicine

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

Date for review to be initiated by	
Name of school/setting	
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine
Medicines **must** be in the original container as dispensed by the pharmacy

Name/type of medicine (as described on the container)	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know?	
Self-administration – y/n	
Procedures to take in an emergency	

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	[name of agreed member of staff]

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**. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s): DATE:

Record of Medicine Administered to an Individual Child

Name of school/setting	
Name of child	
Date medicine provided by parent	
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	
Quantity returned	
Dose and frequency of medicine	

1st staff signature: _____ Signature of parent: _____

2nd staff signature: _____

Date:			
Time given			
Dose given			
Name of TWO members of staff supervising			
TWO Supervising staff initials/signature			

Date:			
Time given			
Dose given			
Name of TWO members of staff supervising			
TWO Supervising staff initials/signature			
Date:			

Time given			
Dose given			
Name of TWO members of staff supervising			
TWO Supervising staff initials/signature			

Date:			
Time given			
Dose given			
Name of TWO members of staff supervising			
TWO Supervising staff initials/signature			

Date:			
Time given			
Dose given			
Name of TWO members of staff supervising			
TWO Supervising staff initials/signature			