Wilton Primary School - Parental Agreement for Administration of Medicine

Name of child	
Date of birth	
Year Group	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Dosage and method	
Timing	
Special precautions/other instructions	
Self-administration – y/n	

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

Contact Details

Name	
Contact telephone no.	
Relationship to child	
I understand that I must deliver the medicine personally to	The School Office

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering 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 medication or if the medicine is stopped.

Parental Signature _____ Date _____

Date					
Time given					
Dose given					
Name of staff member					
Staff initials					

Date					
Time given					
Dose given					
Name of staff member					
Staff initials					

Name of child:

Date					
Time given					
Dose given					
Name of staff member					
Staff initials					

Date					
Time given					
Dose given					
Name of staff member					
Staff initials					

Date					
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Dose given					
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