CHRIST CHURCH CoE PRIMARY SCHOOL

PARENTAL AGREEMENT for SCHOOL TO ADMINISTER MEDICINE

This form is for **SHORT-TERM MEDICATION** (e.g. antibiotics)

PLEASE NOTE: The school will not give your child medicine unless you complete and sign this form.
This is part of the robust Managing Medicines Policy that is followed by the school.
A separate form should be used for each different type of medicine.

CHILD's NAME	
DATE of BIRTH	
YEAR / CLASS	

ILLNESS / MEDICAL CONDITION	
MEDICINE NAME & STRENGTH	
EXPIRY DATE	
DOSE / QUANTITY TO BE GIVEN	
WHEN TO BE GIVEN	
ANY OTHER INSTRUCTIONS e.g. before / after food	

PLEASE NOTE: ***Medicines must be in the original container with all packaging and instructions.***

GP NAME & CONTACT NUMBER	

This information is, to the best of my knowledge, accurate at the time of writing.

I give consent for school staff to administer medicine in accordance with the instructions above and in line with the school policy.

I will inform the school immediately, in writing, if there is any change to the dose or frequency of the medicine.

YOUR NAME	
YOUR RELATIONSHIP TO CHILD	
YOUR CONTACT NUMBER	
DATE FORM COMPLETED	
SIGNATURE	

CHRIST CHURCH CoE PRIMARY SCHOOL

PARENTAL AGREEMENT for SCHOOL TO ADMINISTER MEDICINE

This form is for **OCCASIONAL MEDICATION** (e.g. inhalers)

PLEASE NOTE: The school will not give your child medicine unless you complete and sign this form.
This is part of the robust Managing Medicines Policy that is followed by the school.
A separate form should be used for each different type of medicine.

CHILD's NAME	
DATE of BIRTH	
YEAR / CLASS	

ILLNESS / MEDICAL CONDITION	
MEDICINE NAME & STRENGTH	
EXPIRY DATE	
DOSE / QUANTITY TO BE GIVEN	
TIME / WHEN TO BE GIVEN	
ANY OTHER INSTRUCTIONS e.g. before / after food	
ANY KNOWN SIDE-EFFECTS	
MY CHILD CAN SELF-ADMINISTER THEIR MEDICATION: YES NO	

PLEASE NOTE: ***Medicines must be in the original container with all packaging and instructions.***

GP NAME & CONTACT NUMBER	

My child has no known allergy to the medicine listed above.

This information is, to the best of my knowledge, accurate at the time of writing.

I give consent for school staff to administer medicine in accordance with the instructions above and in line with the school policy. I will inform the school immediately, in writing, if there is any change to the dose or frequency of the medicine.

PLEASE NOTE: For long-term medication, you will be asked to complete this form at the start of every academic year. You will need to take all medication home at the end of the school year.

YOUR NAME	
YOUR RELATIONSHIP TO CHILD	
YOUR CONTACT NUMBER	
DATE FORM COMPLETED	
SIGNATURE	

CHRIST CHURCH CoE PRIMARY SCHOOL

SCHOOL RECORD OF MEDICINE ADMINISTRATION

This form is for **ALL MEDICATION** administered in school (including self-administration such as inhalers).

CHILD's NAME	
ILLNESS / CONDITION	
MEDICINE & DOSAGE	

DATE			
TIME GIVEN			
DOSE GIVEN			
STAFF NAME			
STAFF SIGNATURE			

DATE			
TIME GIVEN			
DOSE GIVEN			
STAFF NAME			
STAFF SIGNATURE			

DATE			
TIME GIVEN			
DOSE GIVEN			
STAFF NAME			
STAFF SIGNATURE			

DATE			
TIME GIVEN			
DOSE GIVEN			
STAFF NAME			
STAFF SIGNATURE			