Delph Primary School

Administration of Medicines - Parental Agreement Form

Child's Name		**Class**	
D.O.B		**Doctors Name/Contact**	

School will only give your child medicine if you complete, sign and date this form, and the Headteacher has agreed that school staff can administer the medication.

PLEASE NOTE: All medicines must be in the original container as dispensed by the pharmacy. All medicines must be handed in at the school office.

Medical Condition or illness: _____

Name / type of medicine: _____

Date dispensed: _____ **Expiry Date:** _____

How long will your child need to take this medication? _____

Self-administration. Would you like your son/daughter to take his/her own medicine? (please tick one of the boxes)

- ☐ YES
- ☐ NO

Full directions for use: (including dosage, method, timing, aftercare)

Are there any side effects that we need to be aware of /any special precautions?

Procedures to take in an emergency:

Emergency Contact Number:_____ Name:_____

Signed:_____Parent /Guardian Date:_____