

Reeth Community and Gunnerside Methodist Primary Schools



Parental agreement for setting to administer medicine and record of medicine administered

Form A – for short-term/temporary conditions.

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

Name of school/setting	
Name of child	
Date of birth	
Group/class/form	
<i>Short-term</i> medical condition or illness	
Expiry date of this agreement	

Medicine

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

Name/type of medicine <i>(as described on the container)</i>	
Expiry date	
Date and time the most recent dose was given (school should not give the first dose of a medicine)	
Dosage and method to be administered <u>at lunchtime</u>	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – y/n	

In the case of an emergency you will be contacted by telephone as per our emergency contact records held by the school office.

Parent Consent:

- I understand that I must deliver the medicine and the appropriate dispensing measure personally to the school office at the appropriate site.
- 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's policy and the prescriber's instructions.
- 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 prior to the date that this agreement expires.
- I understand that, where medicine is not self-administered, it will be given by non-medically qualified staff.
- I agree not to hold staff responsible for loss, damage or injury when undertaking agreed administration/supervision of medication unless resulting from their negligence.
- I will ensure adequate supply of in date medication for the duration of this agreement.

Name of parent _____ Relationship to child _____

Signature _____ Date _____

Please see overleaf for record of medicine administered in accordance with the above agreement.

Record of Medicine Administered

Date

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Time given

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Dose given

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Name of member of staff

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Staff initials

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Witness initials

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Date

--	--	--	--

Time given

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Dose given

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Name of member of staff

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Staff initials

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Witness initials

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