M5

WARGRAVE HOUSE SCHOOL & COLLEGE

Parental Agreement for school/setting to administer medicine

The school/setting will not give your child medicine unless you complete and sign this form

Name of Child	
Date of Birth	
Group/class	
Medical condition or illness	

Medicine	**Prescribed**	**Non-Prescribed**
Name/type of medicine (*as described on the container)*		
Expiry Date		
Dosage and Method (e.g. mg/ml)		
Special precautions e.g. to be taken on an empty stomach/ e.g. at least 4 hrs between doses		
Are there any side effects that the school/setting needs to know about?		
Self administration	Yes/No (delete as appropriate)	Yes/No (delete as appropriate)
Procedures to take in an emergency		

Approximate Timing (please tick the appropriate box)

Breakfast 7.00am-9.00 am ☐	Lunchtime 11.45am-1.30pm ☐	Teatime 5.00pm-6.00 pm ☐
Bedtime 8.00pm-9.00pm ☐	Per required need ☐	Other (please state specific time) _____ am _____ pm

Non-Prescribed Medicine (Over-the-Counter OTC Medicine)

	I confirm my child has taken this over-the-counter medicine before without ill effect.
	I confirm this over-the-counter medicine does not interact with the other medicines my child is taking and is not contraindicated with my child's medical condition

ALL MEDICATION MUST BE IN ORIGINAL PACKAGING WITH PRESCRIPTION LABEL IF APPLICABLE

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	

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.
THIS FORM MUST BE COMPLETED AND SIGNED BY A PERSON WITH PARENTAL RESPONSIBILITY.

Date: _____ Signature(s) _____

IF MORE THAN ONE MEDICINE IS TO BE GIVEN A SEPARATE FORM SHOULD BE COMPLETED FOR EACH ONE.