

Parental agreement for Downsway School to administer prescribed medicine

The school will not give your child medicine unless you complete and sign this form and the school or setting has a policy that the staff can administer prescribed medicine.

Name of school/setting	Downsway Primary School
Name of child	
Date of birth	
Year group	
Medical condition or illness	

Medicine

Name/type of prescribed medicine	
Dosage amount (eg. 5ml)	
Timing (eg. 12pm)	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	

Emergency Contact Details

Name	
Daytime telephone no.	
Relationship to child	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to 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.

Signature: _____

Date: _____

