**Parental agreement for Townley School and Nursery to administer prescribed medicine**

The school **will not** give your child medicine unless this form is completed and signed. Parents/carers must provide the medicine in its original container and must have been dispensed by a pharmacist and have the label showing:

* Name of child:
* Name of medicine:
* Method of administration:
* The instruction leaflet with prescribed medicines should show:
* Any side effects
* Expiry date

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date for review to be initiated by |  | | | | |
| Name of school/setting |  | | | | |
| Name of child |  | | | | |
| Date of birth |  |  |  | |  |
| Group/class |  | | | | |
| Medical condition or illness |  | | | | |
| Name/type of medicine  *(as described on the container)* |  | | | | |
| Expiry date |  |  |  | |  |
| Dosage and method |  | | | | |
| Quantity received by school |  | | | | |
| Timing |  | | | | |
| Special precautions/other instructions e.g. storage |  | | | | |
| Are there any side effects that the school/setting needs to know about? |  | | | | |
| Self-administration – y/n |  | | | | |
| Procedures to take in an emergency |  | | | | |
| Quantity returned |  | | | Date: | |
| **NB: Medicines must be in the original container as dispensed by the pharmacy**  **Contact Details** | | | | | |
| Name |  | | | | |
| Daytime telephone no. |  | | | | |
| Relationship to child |  | | | | |
| Address |  | | | | |
| I understand that I must deliver the medicine personally to | [agreed member of staff] | | | | |

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.

Name Signature(s)

Date

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Recepit of medication confirmed by: | |  |  |  | |
| Date medicine provided by parent |  |  |  |  | |
| Quantity received |  | | | | Date |
| Witness by (in case of controlled drugs) |  | | | | Date |
| Name and strength of medicine |  | | | | |
| Expiry date |  |  |  |  | |
| Dose and frequency of medicine |  | | | | |
| Quantity returned to parent |  | | | | Date |

Authorisation to administer medication approved by headteacher (or senior teacher)

Name Role

Signature Date