FOX WOOD SCHOOL

PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

The school will only give your child medicine when you complete and sign this form, and the school has a policy that staff can administer medicine when trained to do so.

|  |  |
| --- | --- |
| Name of School | FOX WOOD SCHOOL |
| Name of Pupil |  |
| Date of birth |  |
| Class |  |
| Medical condition or illness |  |
| Medicine |  |
| Name/type of medicine (as described on container) |  |
| Date dispensed |  |
| Expiry date |  |
| Dosage and method ie, syringe, spoon, in a drink |  |
| Timing |  |
| Special precautions or allergies |  |
| Are there any side effects that the school needs to know about? |  |
| Procedures to take in an emergency |  |
| Contact Details |  |
| Name |  |
| Daytime telephone number |  |
| Relationship to child |  |
| Address |  |
| I understand that the medicine must be delivered to school by myself or a named responsible adult. I understand that medicines must be in the original container as dispensed by the pharmacy  I accept that this is a service that the school is not obliged to undertake.  I will notify the school of any changes in writing | |

Date: ………………………………… Signature: ………………………………………

Reviewed: …………………………..

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| **MEDICATION:** | | | | | **Medical condition or illness :** | | | | |  |
|  | **Monday** |  | **Tuesday** |  | **Wednesday** |  | **Thursday** |  | **Friday** |  |
| **Week beginning** | **Time given** | **Signature**  **x 2** | **Time given** | **Signature**  **x 2** | **Time given** | **Signature**  **x 2** | **Time given** | **Signature**  **x 2** | **Time given** | **Signature**  **x 2** |
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