GREENHAUGH PRIMARY SCHOOL

Parental Agreement for School to Administer Prescribed Medicine

School will not give your child medicine unless you complete this form, and the school has a policy that staff can administer prescribed medicine.

Name of School: **Greenhaugh Primary School**

Date: _____

Child's Name: _____

Date of Birth: _____

Address: _____

_____

Year Group: _____

Name and Strength
Of Medicine: _____

Expiry Date: _____

How much to give
(i.e. dose to be given): _____

Any other instructions: _____

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

Daytime phone number of
Parent or adult contact: _____

Agreed review date to be
Initiated by Mrs Crow: _____

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with school policy.

Parent's Signature: _____

Print Name: _____

If more than one medicine is to be given a separate form should be completed for each one.