MANORCROFT PRIMARY SCHOOL

Parental Agreement for School to Administer Medication (short term)

Name of child	
Date of birth	
Class	
Medical condition / illness	

Medicine:

Name / type of medicine (as described on the container)	
Expiry date	
Dosage and method	
Timing	
Special precautions / instruction	
Are there any side effects that the school should know about?	
Self-administration	Yes / No
Procedures to take in an emergency	

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

Contact Details:

Name	
Daytime telephone no.	
Relationship to child	
Address	

I agree to members of staff administering medicines/providing treatment for my child as directed above

	Parent/Guardian	**School Representative**
Signature		
Print name		
Date		