

Parental agreement to administer medicine

Name of school/setting:

Childs' Name:

Date of Birth:

Address:

Name of person who brought it in:

Medical condition being treated:

Do they have parental responsibility? Yes / No

Date	Name of Medication	Amount Supplied	Individual Health Care plan completed (Y/N + date)	Expiry Date	Date medication no longer required (if known)	Dosage regime (must match prescribers/manufacturers instruction)

Any known side effects or special precautions to be aware of?

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.

Signature of parent/carer _____ Staff Signature _____

Date _____