



Parental agreement for school to administer prescribed medication only.

Ashley CofE Primary School will not give your child **prescribed medicine** unless you complete and sign this form. **All forms and medicines must be handed in to the school office.**

Name of child

Date of birth

Class

Medical condition or illness

MEDICINE

Name/type of medicine

(as described on the container)

Expiry date

Dosage and method

Timing

Special precautions/other instructions

Are there any side effects that the school
needs to know about?

Self-administration

Procedures to take in an emergency

YES/NO*

**delete as necessary*

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

CONTACT DETAILS

Name

Daytime telephone no.

Relationship to child

This is to confirm that I give consent to Ashley CofE Primary School staff administering prescribed medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature.....

Date.....