Parental Agreement for Medication Administration

Marriotts School will not give your child medicine unless you complete and sign this form.

Name of child	
Date of birth	
Tutor group	
Medical condition or illness	
Date for review to be initiated	

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/setting needs to know about?	
Self-administration – y/n	
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 understand that I must deliver the medicine personally to	Marriotts School Reception

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(s) _____ Date _____

Record of medicine administered to an individual child

Name of child	
Date medicine provided by parent	
Tutor group	
Quantity received	
Name and strength of medicine	
Expiry date	
Dose and frequency of medicine	

Staff signature _____

Date			
Time given			
Dose given			
Quantity remaining			
Administered by			

Date			
Time given			
Dose given			
Quantity remaining			
Administered by			

Date			
Time given			
Dose given			
Quantity remaining			
Administered by			

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Dose given			
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Administered by			

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Time given			
Dose given			
Quantity remaining			
Administered by			

Date			
Time given			
Dose given			
Quantity remaining			
Administered by			

Quantity returned	
Medication collected by	Name:
	Signature:
	Date:

If not collected – medication disposed of by	Name/Date