**Appendix A**

# Parental Agreement for Setting to Administer Medicine

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

|  |  |
| --- | --- |
| Date for review  | 12 months from date of consent or upon expiry of the prescription, whichever is sooner |
| Name of school/setting | Archbishop Sancroft High School |
| Name of child |  |
| Date of birth |  |  |  |  |
| Form |  |
| 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/setting needs to know about? |  |
| Self-administration – yes/no (if no, please discuss with School Office staff) |  |
| Procedures to take in an emergency |  |
| GP name and telephone number |  |
| **NB: Medicines must be in the original container as dispensed by the pharmacy****Paracetamol (supplied by school)**I **give consent / do not give consent** (please delete as appropriate) for the school to administer **one / two x 500mg** (please specify dosage) paracetamol tablets if required by my above named child. I understand that the school office will also telephone for my verbal consent on each occasion.**Contact Details** |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
| I understand that I must deliver the medicine personally to | School Office staff |

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

(Parent/Carer/Guardian/Person with parental responsibility)