**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)