PARENTAL AGREEMENT FOR LINGFIELD STAFF TO ADMINISTER MEDICINE

Medication cannot be administered without the completion of this form.

Name of child				
Date of birth				
Form				
Medical condition or illness				
Medicine				
Name/type of medicine *(as described on the container)*				
Prescribed over the counter	Yes / No *please circle*			
Expiry date				
Dosage and method				
Timings				
Special precautions/other instructions				
Are there any side effects that the school needs to know about?				
Self-administration	Yes / No *please circle*			
Medication should be refrigerated	Yes / No *please circle*			
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	Mrs Nolan (School Office)

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering 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(s) ___________________ Date___________________________