

## Parental Agreement for School to Administer Medicine

Willington Primary School will not give your child medicine unless you complete and sign this form. Please note the medication must be prescribed by a health professional and be in an original container as dispensed by the pharmacy

Name of Setting	Willington Primary School
Name of child	
Date of birth	
Class	
Medical condition or illness	

### Medicine

Name/Type of medicine	
Expiry date	
Dosage and method	
Timing	
Other instructions	
Are there any side effects we need to know about?	
Self-administration – y/n	

### Contact details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	[agreed member of staff]

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Willington Primary School staff administering medicine in accordance with school policy. I will inform Willington Primary School immediately if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature \_\_\_\_\_

Date \_\_\_\_\_