

Eastnor Primary School

Parental agreement for school to administer medicine

My child (Pupil's name)

Group/Class/form.....

has been prescribed medication by
(Consultant's name and surgery)

Surgery telephone number.....

I request that Eastnor Primary School staff administer, on my behalf, the following medication that is required At School:

Name and strength of Medication(s)	Dosage (no. of tablets and dosage of each tablet)	Time to be given	Expiry date

Any other instructions

Daytime phone number of parent or adult contact.....

.....

Signed: Date:

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 and when the medication stops.