Shustoke C of E Primary School
Agreement to Administer Medication

Child's Name:
Date of Birth:
Class: (Please circle) R 1 2 3 4 5 6
Name of Medicine:
Date Dispensed:
Expiry Date:
Self-administration?: (Please circle) Yes No
How much to give (dose) and method:
When to be given:
Any other instructions (for example storage):
Daytime Phone number of parent or carer:
Relationship to Child:

The above information is to the best of my knowledge accurate at the time of writing and I give my consent to school staff administering the medication in accordance with the school policy.

I understand that I must deliver the medicine personally to the main office or Mrs Griffin in the SEND office. Medicines should be in the same container as dispensed by the pharmacy.

Signed: …… (parent/carer)

Print Name: ……..

Date: …….