

Agreement for school to administer prescribed medication

School Name	Whittington C.E. Primary School
Head Teacher	

Pupil details:

Name of pupil	
Date of birth	
Class/group/form	
Medical condition	

Medication details:

Name of medicine (as described on container)	
Date dispensed	
Expiry date	
Review of long term medication if applicable	Staff Name Review Date

Administration:

Dosage and method	
Timing	
Special precautions	
Side effects that school needs to know about	
Self administration; please tick.	Yes No
Procedures in an emergency	

Contact details:

Name	
Relationship to pupil	
Daytime phone number/s	
Address	

- I understand that I must deliver the prescribed medicine personally to (agreed member of staff) and that the medicine should be in the same container as dispensed by the pharmacy.
- The above information is to the best of my knowledge accurate at time of writing and I understand that I must notify the school of any changes in writing.
- I the undersigned consent to the administration of the prescribed medicine as detailed above:

Parent/legal guardian's name	
Parent/legal guardian's signature	
Date:	

Record of administered medication

[illegible]