# Wilson's School - Parental Agreement for School to Administer Medicine

The school will not store or give your child medicine unless you complete and sign this form and return it to the school. Medicine must be in its original container as dispensed by the pharmacy, clearly marked with your child's name, the expiry date and dosage details. One form to be completed per medication, please.

| | | | | |
|---|---|---|---|---|
| Pupil's Name | | | | |
| Date of birth | | | | |
| Form | | | | |
| Medical condition or illness | | | | |

**Medicine**

| | | | | |
|---|---|---|---|---|
| Name/type of medicine *(as described on the container)* | | | | |
| Expiry date | | | | |
| Dosage and method | | | | |
| Timing | | | | |
| Special precautions/other instructions | | | | |
| Are there any side effects that the school needs to know about? | | | | |
| Self-administration – Yes or No? | | | | |
| Procedures to take in an emergency | | | | |

**Contact Details**

| | |
|---|---|
| Name | |
| Contact telephone number(s) | |
| Relationship to pupil | |
| Address | |

I understand that I must deliver the medicine personally to the school Reception. 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. I will collect the medicine at the end of the course/upon the expiry date and dispose of it safely.

Signature _____ Date _____