# Administration of Medication to Pupils - Agreement between Parents and School (Appendix 1)

***Note: Medicines must be kept in the original container or packaging.***

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| **To the Headteacher: Belinda Athey** *(add name)* | **School: Whittingham C of E Primary School** |
| My child *(name)* _____ Date of birth:_____<br>Class_____ has the following medical condition_____<br>I wish for him/her to have the following medicine administered by school staff, as indicated below: | |
| Name of Medication: | |
| Has this been prescribed by a medical practitioner? Yes/No | |
| Dose/Amount to be given: | |
| Time(s) at which to be given: | |
| Means of administration: | |
| How long will the child require this medication to be administered? | |
| Known side effects and any special precautions (please attach details) plus procedures to take in case of emergency | |
| Other Information (e.g.from GP/Pharmacist): | |
| ***Emergency Contact 1***<br>Name: _____<br>Telephone<br>*Work*: _____<br>*Home*: _____<br>*Mobile*: _____<br>Relationship: _____ | ***Emergency Contact 2***<br>Name:_____<br>Telephone<br>*Work*: _____<br>*Home*: _____<br>*Mobile*: _____<br>Relationship: _____ |
| *I undertake to deliver the medicine personally to the Headteacher or Medication Coordinator and to replace it whenever necessary. I also undertake to inform the school immediately of any change of treatment that the doctor or hospital has prescribed.* | |

Name: _____ Signature: _____

Relationship to child: _____ Date: _____

**Part 2 - To be completed by Headteacher/Medication Coordinator**

**Confirmation of agreement to administer medicine**

It is agreed that *(child)* _____ will receive (*quantity and name of medicine)*

_____every day at (*time medicine to be administered, for example,*

*lunchtime or afternoon break)* _____.

*(Child)* _____ will be given medication or supervised whilst he/she takes it by

(*name of member of staff)* _____.

This arrangement will continue until_____ *(either the end date for the course of medicine or until the parents instruct otherwise).*

Name: _____ Signature: _____
*Headteacher/Medication Coordinator*

School: _____