GOSFORTH CENTRAL MIDDLE SCHOOL
MEDICINES IN SCHOOL

PARENTAL AGREEMENT FOR SCHOOL/SETTING TO ADMINISTER MEDICINE

The school/setting will not give your child medicine unless you complete and sign this form and the school or setting has a policy that staff can administer medicine.

PUPIL DETAILS	
Full Name	
Date of Birth	
Registration Class	

MEDICAL INFORMATION *(Medicines must be in the original container as dispensed by the pharmacy)*	
Medical Condition Requiring Medication	
Name of Medication	
Date Dispensed	
Expiry Date	
Review Date	
Self- Administration?	☐ Yes ☐ No
Dosage and Method of Administration	
Timing(s) of Administration	
Special Precautions	
Are There Any Side Effects That The School Needs To Know About?	
Procedures To Be Taken In An Emergency	

PARENT / GUARDIAN DETAILS		
Title:	☐ Mr ☐Mrs ☐Ms ☐ Miss ☐ Dr ☐ Other *(please specify)* ……	
Surname:		
Forename:		
Relationship to Pupil:		
Telephone Numbers:	**Home:**	
	Mobile:	
	Work:	

CONTINUED OVERLEAF

EMERGENCY CONTACT 1		
Title:	☐ Mr ☐Mrs ☐Ms ☐ Miss ☐ Dr ☐ Other *(please specify)* ……..	
Surname:		
Forename:		
Relationship to Pupil:		
Telephone Numbers:	**Home:**	
	Mobile:	
	Work:	

If you have any further information that you would like to provide the school about your child's medical condition, please use the additional space on page 3.

PARENT/GUARDIAN DECLARATION

- The above information is, to the best of my knowledge, accurate at the time of writing.
- I give consent for the school to administer medicine in accordance with the Medical Administration Policy.
- I accept that this is a service that the school is not obliged to undertake.
- I understand that I am responsible for ensuring that there are sufficient supplies of medication in school for my child at all times.
- I understand that I must deliver this medication personally to the **School Office**.
- I understand that I must notify the school, **in writing**, of any changes to dosage or frequency of administration, or if the medication is stopped.

Parent / Guardian signature…….. Date……

Print Name……..

ADDITIONAL INFORMATION *(Please use this space to provide any further information that you believe school should be aware of in relation to your child's medical condition).*