

Agreement for Arnold Lodge School to administer medicine

Name of child	
Date of birth (dd/mm/yy)	
Form	
Medical condition or illness	
Medicine	
Name/type of medicine (as described on the container)	
Date dispensed	
Expiry date	
Agreed review date to be initiated by [name of member of staff]	
Dosage and method	
Timing	
Special precautions	
Are there any side effects that the school needs to know about?	
Self administration	Yes/No (delete as appropriate)
Procedures to take in an emergency	
Contact Details	
Name	
Daytime telephone no.	
Relationship to child	
Address	

- I understand that I must deliver the medicine personally to the school nurse or reception and that medicines should be in the same container as dispensed by the pharmacy.
- The above information is to the best of my knowledge accurate at the time of writing and I understand that I must notify the school/setting of any changes in writing.

Parent's Signature(s).....

Date

I consent to staff administering the above to me.

Child's signature (wherever possible).....