



Parent/Carer Agreement for Self-Administration of Prescribed Medication

Please complete this form, giving all details, if you wish to give permission for your child to self-administer medication.

Please use block print throughout

Child's Name:		Year:	Form:
Address:			
Date of Birth:		Condition of illness:	
Name/Type of Medication: (as described on the container)		Storage requirements:	
How long does your child need to take medication:		Dosage and method:	
Timing of medication:		Date dispensed:	
Special Precautions:			
Possible Side Effects:			
Parent Emergency Contact Telephone No:			
Doctor:	Surgery:	Tel No:	
Procedure to take in an Emergency:			
Contact Details:			
Name:			
Daytime telephone number:			
Relationship to child:			
<p>Parent/Guardian Consent: I give permission for my child to self-administer the medication named above in accordance with advice from the Doctor/Pharmacist.</p> <p>Medication is to be handed to reception each day and secured in the office at all times. The named pupil will access medication at the appropriate times as stated above.</p>			
Signed		Print Name.....Parent/Guardian	
Date			
Signed.....		Print NameN-B Academy Staff	
Notes:			
<p>Please hand this form in at the Academy Reception together with your prescribed medicine.</p>			