worcestershire countycouncil

Pitmaston Primary School and Pre-School Nursery

Agreement for school to administer prescribed medication

School Name	
Head Teacher	

Pupil details:

Name of pupil	
Date of birth	
Class/group/form	
Medical condition	

Medication details:

Name of medicine (as described on container)	
Date dispensed	
Expiry date	
Agreed review date (initiated by identified staff member	**Staff Name** **Review Date**

Administration:

Dosage and method	
Timing	
Special precautions	
Side effects that school needs to know about	
Self administration; please tick.	**Yes** **No**
Procedures in an emergency	

Contact details:

Name	
Relationship to pupil	
Daytime phone number/s	
Address	

- **I understand that I must deliver the prescribed medicine personally to (agreed member of staff) and that the medicine should be in the same container as dispensed by the pharmacy.**

- **The above information is to the best of my knowledge accurate at time of writing and I understand that I must notify the school of any changes in writing.**

- **I the undersigned consent to the administration of the prescribed medicine as detailed above:**

Parent/legal guardian's name	
Parent/legal guardian's signature	
Date:	

I consent to staff administering the above to me:

Signature of pupil (where ever possible):