MILLTHORPE SCHOOL

AGREEMENT FOR ADMINISTRATION OF MEDICATION

This form must be completed by Parents and approved by the Headteacher prior to the administration of any medication.

PUPIL NAME: ………………………………………………………….. TUTOR GROUP: ………………..

MEDICINE 1:

Name & Strength	Expiry Date	Dose to be given	Time to be given	Other instructions

MEDICINE 2:

Name & Strength	Expiry Date	Dose to be given	Time to be given	Other instructions

MEDICINE 3:

Name & Strength	Expiry Date	Dose to be given	Time to be given	Other instructions

MEDICINE 4:

Name & Strength	Expiry Date	Dose to be given	Time to be given	Other instructions

N.B: All medicines must be in the original container as dispensed by the pharmacy

Name & daytime phone number of parent/adult contact: ………..…………………………………..…..

Name and telephone number of child's GP: ………………………..……………………………………

I apply for Millthorpe school staff to administer medication to my child (or supervise my child self-administering medication) as detailed above, in accordance with Millthorpe School's policy. I will inform Millthorpe School immediately and in writing if there is any change in dosage or frequency of the medication or if the medication ceases.

Arrangements for the administration of medication by the school will automatically expire at the end of each school year. If administration of medication is to continue, a new agreement must be applied for at the beginning of the new school year.

All enquiries/correspondence regarding pupil medication should be directed to the Office Manager.

Parent/Carer's Signature: …………………………………………. Date: …………………………….

I approve this application for administering of medication by Millthorpe school staff as detailed on this form and in accordance with the school policy.

Headteacher's Signature: ………………………………………… Date: ……………………………..

OFFICE USE ONLY:	COPY PARENTS		COPY OFFICE MANAGER		FILE COPY	