**FORM 3A**

**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.

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| --- |
| ROBY PARK PRIMARY SCHOOL |

Name of School/Setting

|  |
| --- |
|  |

Name of Child

Date of Birth / /

|  |
| --- |
|  |

Group/Class/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

|  |
| --- |
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|  |

Are there any Side Effects that the

School/Setting 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 (*agreed member of staff)*

# 

# SCHOOL OFFICE

I accept that this is a service that the school/setting is not obliged to undertake. I understand that I must notify the school/setting of any changes in writing.

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_