



## Agreement to Administer Medicine

Date:	
Child's name:	
DOB:	
Year/Class:	
Allergies:	
Name and strength of medicine:	
Medication expiry date:	
Treatment for:	
Dosage and time:	
Duration of course:	
Associated side effects related to medication:	
Any other instructions: (What do if goes on a school trip/outings, medicines left in school)	Medication to be kept in a locked cupboard/box. Check child's name, medication and expiry date of medication.
Name and phone no. of GP if different from Monkfield Medical Practice	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent/Carer signature: ..... Print Name.....

Date: .....

Signed on behalf of the school..... Print Name: .....

Date: .....

