



## Landkey Community Primary Academy Parental agreement for setting to administer medicine

The school will not give your child medicine unless you complete and sign this form.

Date for review to be initiated by

Name of child

Date of birth

Class

Medical condition or illness


### Medicine

Name/type of medicine  
*(as described on the container)*

Expiry date

Dosage and method

Timing

Special precautions/other  
instructions

Are there any side effects that the  
school/setting needs to know about?

Self-administration – y/n

Procedures to take in an emergency


**NB: Medicines must be in the original container as dispensed by the pharmacy**

### Contact Details

Name

Daytime telephone no.

Relationship to child

GP name.

GP telephone no.

I understand that I must deliver the  
medicine personally to


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

Signature(s) \_\_\_\_\_  
Parents Name \_\_\_\_\_

Date \_\_\_\_\_