APPENDIX B

Loughton School

Parental agreement for school to administer non-prescribed medicine

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

Name of Child _____

Date of Birth _____

HB _____

Medical Condition/Illness _____

Medicine

Name/Type of Medicine _____
(as described on the container)

Date Dispensed _____

Expiry Date _____

Agreed review date to
be initiated by _____

Dosage and method _____

Frequency _____

_____

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

Self-administration YES / NO *(delete as appropriate)*

Procedures to take in an
emergency _____

Contact Details

Name _____

Daytime telephone No _____

I understand that this is a service that the school is not obliged to undertake.
I confirm that my child has taken this medication before and not had any adverse side effects.

I understand that I must notify the school of any changes in writing, if here is any change in dosage or frequency of the medication or the medicine is stopped.

Signed _____ Date _____

Headteacher agreement to administer medicine

It is agree that *(Name of Child)* _____ *will receive the medicine as stated above.*

He/She will be supervised whilst he/she takes their medication by a member of staff.

This arrangement will continue until either the end day of course of medicine or until instructed by parents.

Signed _____