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we Achieve, we Believe, we Care

## Supporting Pupils with Medial Conditions – Appendix C

## Parental Agreement for the School to Administer Medicine

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

Administration of medication form	
Date for review to be initiated by:	
Name of child:	
Date of birth:	
Group/class/form:	
Medical condition or illness:	
Medicine	
Name and/or type of medicine (as described on the container):	
Expiry date:	
Dosage and method:	
Timing:	
Special precautions and/or other instructions:	
Any side effects that the school needs to know about:	
Self-administration – Yes/No:	
Procedures to take in an	
emergency:	

NB: Medicines must be in the original container as dispensed by the pharmacy – the only exception to this is insulin, which may be available in an insulin pen or pump rather than its original container.

Contact details

Name:

Name:	
Daytime telephone number:	
Relationship to child:	
Address:	
I will personally deliver the medicine to:	
writing and I give consent for schoo with the relevant policies. I will inforn	st of my knowledge, accurate at the time of old staff to administer medicine in accordance on the school immediately, in writing, if there is of the medication, or if the medicine is stopped.
Signature	Date