PERRYFIELDS HIGH SCHOOL
SPECIALIST MATHS AND COMPUTING COLLEGE

Agreement for School to Administer Medication

School Name	PERRYFIELDS HIGH SCHOOL
Head Teacher	Mr Ian Barton
PUPILS DETAILS:	
Name of Pupil	
Date of Birth	
Form Group	
Medical Condition	
Medication Details:	
Name of medicine (as described on container)	
Date Dispensed (if dispensed)	
Expiry Date	
Agreed Review Date (initiated by identified staff member)	Staff Name…… Review Date……
Please Note: When a child requires regular analgesia (e.g. for migraines) they parents will need to contact their GP supported and request a Health Care Plan outlining when the students' needs to take the medication.	
Administration:	
Dosage and Method	
Timing	
Storage (Fridge/locked cupboard)	
Side effects that school needs to know about	
Self-Administration – please circle	Yes No

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Agreement for School to Administer Medication continue.

Contact Details:	
Parent(s)/ Carer (s) Full Name	Pupils Name:
Relationship to Pupil (Parental responsibility only)	
Daytime Phone Numbers	
Address	
• **The above information is to the best of my knowledge accurate at time of writing and I understand that I must notify the school of any changes in writing.** • **I the undersigned consent to the administration of the prescribed medicine as detailed overleaf.**	
Parent/Carers Name	
Parent/Carers Signature	
Date	
I Consent to Staff Administering the above to me:	**Signature of Pupil (where ever possible)**

Please Note: It is not School policy to administer over the counter medicines e.g. cough medicine, hay fever tablets