Parental agreement for The Whitstable School to administer medicine –OTC/POM/Controlled

The Whitstable School will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

Date for review to be initiated by	……../……../…….. Welfare Department
Name of school	The Whitstable School, Bellevue Road, CT5 1PX
Name of child	
Date of birth	
Form Group	
Medical condition or illness	
Medicine	
Name of medicine *(as described on the container)*	
Expiry date / Batch no.	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that The Whitstable School needs to know about?	
Self-administration	Yes / No
Procedures to take in an emergency	

Family Contact Information

Name	
Relationship	
Contact Details	
Mobile	
Email	
Name	

Relationship to child	
Contact Details	
Mobile	
Email	
Medication should be delivered directly to:	The Lead First Aider

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

Name:

Signature(s) Date:

Name:

Signature(s) Date: