**Parental Agreement**

**for the**

**Academy Welfare Officer**

**to Administer**

**Medicine**

We will not give your son/daughter medicine unless you complete and sign this form to allow the Welfare Officer to administer medicine

|  |  |  |
| --- | --- | --- |
| Date: |  |  |

|  |  |  |
| --- | --- | --- |
| Student’s name: |  |  |

|  |  |  |
| --- | --- | --- |
| Tutor Group: |  |  |

|  |  |  |
| --- | --- | --- |
| Name and strength of medicine: |  |  |

|  |  |  |
| --- | --- | --- |
| Expiry date of medicine: |  |  |

|  |  |  |
| --- | --- | --- |
| Dosage |  |  |

|  |  |  |
| --- | --- | --- |
| When to be administered: |  |  |

|  |  |  |
| --- | --- | --- |
| Any other instructions: |  |  |

|  |  |  |
| --- | --- | --- |
| No of tablets or quantity given to Welfare Officer: |  |  |

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

|  |  |  |
| --- | --- | --- |
| Daytime Tel No of parent or adult contact: |  |  |

|  |  |  |
| --- | --- | --- |
| Name & Tel No of GP: |  |  |

|  |  |  |
| --- | --- | --- |
| Agreed review date to be initiated by Welfare Officer: |  |  |

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

|  |  |  |
| --- | --- | --- |
| Parent’s signature: |  |  |

|  |  |  |
| --- | --- | --- |
| Print name: |  |  |

|  |  |  |
| --- | --- | --- |
| Date |  |  |

If more than one medicine is to be given a separate form should be completed for each one.