Dover Grammar School for Boys
Astor Avenue
Dover
Kent CT17 0DQ

APPENDIX 2

PARENTAL PERMISSION FOR THE ADMINISTRATION OF MEDICATIONS AT SCHOOL

Forename				
Surname				
Form Group				
What is the medication for				
Name and strength of medication				
How long is the period of treatment				
Date medication provided by parent				DD/MM/YYYY
Expiry date				DD/MM/YYYY
Quantity returned				
Dose and frequency of medication				
Parents / Carer signature				
Staff signature				

Date									
Time given									
Dose given									
Name of member of staff									
Staff initials									

Date									
Time given									
Dose given									
Name of member of staff									
Staff initials									

Date									
Time given									
Dose given									
Name of member of staff									
Staff initials									

Date									
Time given									
Dose given									
Name of member of staff									
Staff initials									
Date									

Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Parental Agreement

- I agree that the information contained in this plan may be shared with individuals involved with my child's care and education.
- I understand that I must deliver the medicine personally to the School Office and am responsible for ensuring that it is in date and replaced as necessary.
- I understand that I must notify the school of any changes in writing.
- I understand that it is my child's responsibility to go to the School Office for any medication that is needed, unless emergency medication is required.
- I understand that it is my responsibility to collect the medication when it is no longer needed / when my son leaves the school and that if it is not collected it will be disposed of.

Signed ______________________________________ Date __________________________

Print Name ____

Pupil Agreement

- I understand that it is my responsibility to go to the School Office for any medication that is needed, unless emergency medication is required.
- If I am carrying emergency medication with me I understand that I should not pass my medication to another pupil for use.

Signed ______________________________________ Date __________________________

Print Name ____