Avonwood Primary School
The best in everyone™
Part of United Learning

Avonwood Primary School
Parental Agreement for school to Administer Medicine

Please complete and sign this form so that we are able to give your child the medicine that they require.

Name of School **Avonwood Primary**

Child's Name _____ DOB _____ Class _____

Name of Medication _____Dose & method_____

Time(s) to be given _____

Days to start medicine: _____

Date to end medicine: _____

Any other Instructions: _____

Self administered? Y/N

Procedure to take in an emergency: _____

NB: Medicines MUST be in the original container, as dispensed by the pharmacy.

Daytime contact number for Parent_____

Name and contact number for GP: _____

The above information is to the best of my knowledge, accurate at the time of writing and I give consent to school staff to administer the above medication in accordance with the Trust Policy. I will inform the school immediately in writing if there is any change in dosage or frequency of the medication or if the medication is stopped.

Signed _____
Person with parental responsibility

Print Name_____

Dated_____

Avonwood Primary School
Harewood Avenue
Bournemouth
Dorset
BH7 6NB
t: 01202 727910
e: office@avonwoodprimaryschool.org.uk
w: www.avonwoodprimaryschool.org.uk

DATE & TIME	DOSE AMINISTERED	ADMINSTERED BY (Initials)	PRINT NAME

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