

**VALLEY GARDENS MIDDLE SCHOOL**

**AGREEMENT TO ADMINISTER MEDICINE**

Note: Medicines must be in the original container as dispensed by the Pharmacy.

1. Name of child .................................................. Form ...............
2. Name and strength of medicine ............................................................................
3. Date received ...........................................................................
4. Dose and frequency of medicine

(or as printed dosage schedule) ............................................................................

1. Times medication required …………………………………………………………………………
2. Quantity received

(Number of doses/volume) ............................................................................

1. Quantity returned/ date ............................................................................
2. End date of course of medication ............................................................................

| I agree/give consent for my child receiving the above medication which will be administered to them by a member of staff. | |
| --- | --- |
| Signed: | Date: |

| It is agreed that the parent/carer of the above child will notify the school office of any changes. | |
| --- | --- |
| Signed: | Date: |