Fairlawn Green, Shinfield Rise,
Reading, Berkshire. RG2 8EP
Telephone: 0118 987 2588
Fax: 0118 975 8497
admin@whiteknights.wokingham.sch.uk
www.whiteknights.wokingham.sch.uk

@WokinghamKnight

Headteacher Mr F Walker

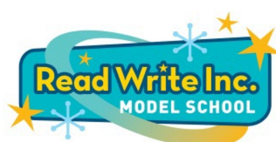
Whiteknights Primary School

Growing Greatness

Parental agreement for Whiteknights Primary School to administer medicine

It is not possible for us to give your child medicine unless you complete and sign this form. Please note that the school is under NO obligation to administer medicines and neither the school nor the governors shall be liable in the event of any loss, damage or personal injury arising in the course of administering medicines, in the absence of any negligent act or omission by them or on their behalf.

Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	
Medicine	
Name/type of medicine *(as described on the container)*	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions eg storage	
Are there any side effects that the school/setting needs to know about?	
Does your child take it themselves?	**Approval from AHT, Inclusion____________**
If they do, is supervision needed?	
Procedures to take in an emergency	
NB: Medicines must be in the original container as dispensed by the pharmacy	



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Contact details	
Name	
Daytime telephone no.	
Relationship to child	
Address	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. I accept that the school will check the dispensed/ expiry date, name and dosage instructions and packaging before accepting any medicine for administration and that the school reserves the right to refuse to accept medication.

Signature(s)______________________ Date _________________________________

_________________________________ __________________________________

For School use only:
Member of staff to initial each box to confirm that the following have been checked before the medicine is accepted for administration:

Name	
Dispensed date	
Expiry date	
Dosage	
Period for which medicine should be administered	
Storage instructions