

 **Crouch Hill Park**

**83 Crouch Hill**

**LONDON**

**N8 9EG**

**Tel: 0207 272 7145**

**Email: info@ashmount.islington.sch.uk**

**Parental Agreement for Administration of Medicine in School**

**Ashmount School has a policy that staff can administer prescribed medication. However, we cannot not give your child medicine unless you complete and sign this form.**

|  |  |
| --- | --- |
| **Name of Child** |  |
| **Date of Birth** |  |
| **Class** |  |
| **Medical condition** |  |

**Medicine**

|  |  |
| --- | --- |
| **Name/Type of Medicine** |  |
| **Expiry Date** |  |
| **Dosage and Method** |  |
| **Timing** |  |
| **Special Instructions** |  |
| **Any side effects?** |  |
| **Self-administration- Y/N** |  |
| **Procedures to be taken in an emergency** |  |

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

**Contact Details**

|  |  |
| --- | --- |
| **Name** |  |
| **Telephone Number(s)** |  |
| **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 the 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.**

**Signature ………………………………………………………………………… Date…………………………………**