

ADUR SPECIAL NEEDS PROJECT

PARENTAL AGREEMENT FOR SETTING SO ADMININSTER MEDICINE

The setting will not give your child medicine unless you complete and sign this form.

Child's Details

| | |
|----------------------------|----------------------|
| Name Of Child: | |
| Date Of Birth: | / / (Day/Month/Year) |
| Medical condition/illness: | |

Medicine Information

| | |
|---|--------------------------------|
| Name Type of Medicine (As described on the container): | |
| Date Dispensed | |
| Expiry Date: | |
| Dosage and Method: | |
| Timing: | |
| Special Precautions: | |
| Are there any side effects that the setting needs to know about? | |
| Self administration: | Yes/no (delete as appropriate) |

Parental Contact Details

| | | |
|-----------------------|-------|------|
| Name: | | |
| Daytime Telephone No: | Home: | Mob: |
| Relationship To Child | | |

I understand that I must deliver the medicine personally to Mrs H Walker or Mss F Wood and accept that this is a service that the setting is not obliged to undertake. Medicines should be in their original packaging.

I understand that I must notify the setting of any changes in writing

| | | | |
|------------|--|-------|-----|
| Signature: | | Date: | / / |
|------------|--|-------|-----|

ASP Agreement

Adur Special Needs Project agree to Administer the medication

| | | | |
|------------|--|-------|-----|
| Signature: | | Date: | / / |
|------------|--|-------|-----|