MOTIVATION AND CHALLENGE FOR ALL

The Blandford School
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THE BLANDFORD SCHOOL

PARENTAL AGREEMENT FOR SCHOOL TO STORE AND SUPERVISE THE TAKING OF MEDICATION

SEPTEMBER 2015 to JULY 2016

STUDENT DETAILS

Name of student	
Date of birth	
Tutor Group	
Medical condition or illness	

MEDICATION (Medication must be in the original container as dispensed by the pharmacy)

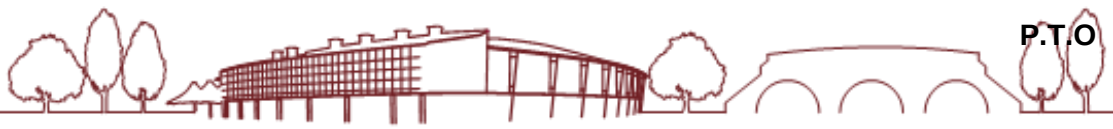
Name/Type of medication	
Date dispensed	
Expiry date	
Agreed review date	**Yearly** ☐ **Monthly** ☐ **Weekly** ☐ **Day to Day** ☐
Dosage and method	
Number of tablet given into school / bottle size	
Timing	
Precautions	
Any side effects	
Procedures to follow in an emergency	

CONTACT DETAILS

Name	
Day time telephone numbers/mobile	
Relationship to child	

I understand that the medication must be delivered to, and kept in the school medical room.
I understand that this is a service that the school is not obliged to undertake.
I understand that I must notify the school of any changes in writing.
Please note if after 6 months no medication is taken in school medication will be disposed off.
(Except students with care plans)

Date _____ **Signature** _____ **Print name** _____



P.T.O

If more than one medicine is to be given a separate form should be completed for each one.

Please write any extra information below.