NOTTINGHAM GIRLS' ACADEMY

Parent/Carer Agreement for Self-administration of Medication with Secure Storage

Please complete this form, giving all details, if you wish to give permission for your child to self-administer medication.

Name of Academy: ....

Pupil's name: ....

Year/Tutor group: ....

Parent/carers name: ....

Telephone number: ....

Name of Medication: …………………………………………………………………………………….

Possible side effects of the medication (if any):

……..

I have provided all necessary additional information about my child's needs as outlined below orattached to this document (including times/frequency of doses)

I give my permission for my child to self-administer the medication named above in accordance with advice from the medical practitioner signed below.
Medication will be handed in at SCIENCE TECH ROOM/BASE 3 each day and secured in a lockable fridge at all times.
The named pupil will access medication at the appropriate times as stated above*.
I have read and understood the Academy Policy for the Management of Medication and want my child exempted from conditions relating to administration by staff.

Signed:.. (Parent / carer)

Signed:……………………………………………………………… (Medical practitioner/nurse)

Signed:.. (Academy staff)

Date: ....