



**KING EDWARD VI
HANDSWORTH GRAMMAR
SCHOOL FOR BOYS**

Educational excellence for our City

PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICATION

Handsworth Grammar School

Please complete this form if medication needs to be administered during the school day.

STUDENT DETAILS

Student Name	
Form Group	
Date of Birth	
Parent/Carer Name	
Contact Number	

MEDICATION DETAILS

Medical Condition	
Name of Medication	
Dosage	
Method of Administration	☐ Oral (tablet, capsule, liquid, syrup) ☐ Inhaler ☐ Topical (cream, ointment, gel) ☐ Eye Drops ☐ Ear Drops ☐ Nasal Spray/Drops ☐ Injection ☐ Other (please specify): _____
Time(s) to be Administered	

Start Date	
End Date	

Date					
Time Given					
Dose Given					
Staff Name and Code					

Special Instructions / Possible Side Effects:

PARENT/CARER CONSENT

- ☐ I request that the above medication be administered to my child as directed.
- ☐ I confirm the medication is in its original pharmacy packaging and clearly labelled.
- ☐ I understand that I am responsible for notifying the school of any changes.

Parent/Carer Signature	Date

FOR SCHOOL USE ONLY

Received By	
Date Received	
Storage Location	
Reviewed By	