



NOTTINGHAM GIRLS' ACADEMY

Parent/Carer Agreement for Self-administration of Medication

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 or attached to this document:

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 stored safely in their bag at all times.

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: