**Abbey View Primary Academy**
Kennedy Avenue, High Wycombe, Bucks HP11 1PZ
Principal: Ms. M. Mirza

Tel.: 0800 206 2244
Email: AVPAinfo@cvpa.school
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# Non- Prescription Medication Form

Parental agreement for the Academy to administer non-prescription medication. **The Academy will not give your child non-prescription medicine unless you complete and sign this form.**

| | |
|---|---|
| Name of academy | |
| Date | |
| Child's Name | |
| Class | |
| Primary Contact number | |
| Relationship to the child | |
| Condition or illness | |
| Name and strength of medication | |
| | |
| Expiry date | |
| Dose to be given | |
| When to be given | |
| Any other instructions | |
| Possible known side effects | |
| Has your child taken this medication before without any side effects? | Please circle either:<br>Yes or No |
| Quantity in bottle/number of tablets given to the academy | |

| | |
|---|---|
| Name of GP | |

Inspiring Futures Partnership Trust

Initial Teacher Training Accredited Provider

Inspiring Futures Partnership Trust: a Company Limited by Guarantee. Registered in England as Number 7977442
Registered Office: Chepping View Primary Academy, Cressex Road, High Wycombe, Bucks, HP12 4PR.
V.A.T. Registration. Number 215-3938-10

| | |
|---|---|
| GP's contact number | |
| GP's address | |
| | |
| Agreed review date | |

The information given is to the best of my knowledge accurate at the time of writing, I give consent to the academy staff administering medicine in accordance with academy policy. **I will inform the Academy immediately in writing if there is a change in dosage or frequency of the medication or if the medication is stopped. I will be responsible for checking the expiry dates on the medication**.

Parent's signature:_____ Date: _____

Print name:_____
If more than one medicine is to be administered a separate form should be completed for each one.

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| **Confirmation of the Principal's agreement to administer medicine** | |
|---|---|
| Name of Academy: **Abbey View Primary Academy** | |
| It is agreed that your child will receive the medication as per the instructions overleaf. This agreement will continue until instructed by parents/carer. | |
| Principal: | |
| Principal: signed: | Date: |

| **Notification of returned medication to parent/carer** | |
|---|---|
| Date returned | |
| Returned by staff member | |
| Parent/carer print name | |
| Parent/carer signature | |