



Record of medicine administered to an individual child

Name of School:

Name of Child:

Date medicine provided by parent

Class

Quantity received:

Name and strength of medicine:

Expiry date:

Quantity returned:

Staff Signature:

Parent Signature:

Date:							
Time Given:							
Dose Given:							
Name of member staff:							
Staff Initials:							

Date:							
Time Given:							
Dose Given:							
Name of member staff:							
Staff Initials:							

Date:							
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Dose Given:							
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Dose Given:							
Name of member staff:							
Staff Initials:							



Parental request for the school to administer medication

The school will not give your child medicine unless this form has been completed and the Headteacher has agreed that staff can administer the medication

Details of Pupil

Surname _____

Forename(s) _____

Address _____

_____ Date of birth _____

_____ Class _____

Medication

Name/Type of Medication _____

For how long will your child take this medication _____

Date dispensed _____

Full directions for use _____

Dosage and method _____

Timing _____

Special precautions _____

Side Effects _____

Self Administration _____

Emergency Procedures _____

Place of Storage _____

Contact Details

Name _____ Relationship to Pupil _____

Daytime telephone number _____

Address _____

I understand that I must deliver the medicine personally to _____

and that the school is not obliged to undertake this service.

Signed _____ Date _____