Medication Record

Date: ……

Student Name: …… Form: ……...

Name of Medication: ……

How much to give (i.e. dose): ……

When to be given and length of treatment: ……

Any other instructions: ……

Name of person able to administer medication: ……..

Phone No. of parent/guardian: ……

Name of GP: ……

GP Telephone number: ……..

Consent
The above information is to the best of my knowledge accurate at the time of writing and I give my consent to school staff administering the medication in accordance with the school and the Education Departments policy.
The school will be notified immediately, of any changes to the above.

Parents Signature: …….. Dated: …….

Print name: ……

If more than one medication is to be given, a separate form should be completed for each.

Record of Medication Administration

Name of Student: …… Form: ……..

Name/type of Medication Administered: ……..

Expiry Date: ……

Date D/M/Y											
Time Given											
Dose											
Staff Name											
Staff initials											