PRESCRIBED MEDICINE RECORD

All medication should be in the original container from the chemist, marked clearly with your child's name and class

Child's Name _____

Class/tutor Group _____

Name of prescribed medicine _____

Strength of medicine if appropriate _____

Expiry date of medication _____

How much to give (i.e.dose) _____

When to be given _____

Any other instructions (include details for inhalers if any) _____

Phone No. of parent or adult contact _____

Tick appropriate box

Medicine to be left at school ☐

Medicine to be taken home each day e.g.antibiotics ☐

In consideration for the Headteacher or the school staff agreeing to give medication to my/our above named child during school hours, I/we agree to indemnify the Headteacher, the school staff and the Local Authority against all claims. Costs, actions and demands whatsoever resulting from the administration of the medicine unless such claims, costs, actions or demands result out of the negligence of the Headteacher, the school staff or the Local Authority.

Parent/Carer's signature. _____

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

DATE												
TIME GIVEN												
SIGN												

Date medicine returned to parent on completion of course of medicine._____

Medicine Record Continued:

DATE													
TIME GIVEN													
SIGN													

DATE													
TIME GIVEN													
SIGN													

DATE													
TIME GIVEN													
SIGN													

DATE													
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