THIS SIDE FOR COMPLETION BY PARENT/CARER

BROOKLAND JUNIOR SCHOOL

ADMINISTERING OF PRESCRIBED MEDICATION

This form must be completed and signed before a designated school first aider can administer medication

Date _____

Child's Name _____

Class _____

Name and strength of medicine _____

Expiry date _____

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

When to be given _____

Any other instructions _____

Note: Medicines must be in the original container as dispensed by the pharmacy

Daytime phone number of parent/Carer _____

Name and phone no. of GP practice _____

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent/Carer signature _____ Name _____

This medical data will be retained and used by the nominated school first aider until the medication is no longer required as directed by the Parent/Carer

FOR SCHOOL USE: RECORD OF MEDICINE ADMINISTERED

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

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