SCHOOL MEDICINE RECORD

I request that medication be given in accordance with the information below by a responsible member of the school staff who has received the relevant training. When necessary this treatment will be administered during educational visits and other out of school activities.

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

Child's full name: _____ Class: _____

Condition or illness: _____

Name of medicine (as described on packaging): _____

Expiry Date: _____

Dosage and method: _____

Timing/when to be given: _____

How long will you child require this medication: _____

Any other instructions/special precautions/side effects: _____

_____

Procedure to take in an emergency: _____

_____

Declaration:

I understand that I must deliver the medication personally, labelled with the child's name and class, to the school staff and accept that this is a service which the school is not obliged to undertake.

Signed (parent/guardian): _____ Date: _____

Emergency contact name & number: _____ & _____

Received by (school staff member): _____ Date: _____

Date										
Time given										
Staff signature										
Dosage										