APPENDIX 2

HOLY TRINITY C.E. JUNIOR SCHOOL

Record of medicine administered to an individual child

The school will not give your child medicine unless you complete and sign this form, and the Headteacher has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Surname:…….

Forename(s):……..

Class:……..M/F:…….. Date of Birth:……..

Address:……. ……

…….

Condition or illness:……..…….

MEDICATION

Name/Type of Medication (as described on the container):……..……

How long will your child take this medication:……..……

Date Dispensed:…… Doctor's Name: ……

Full Directions for Use:

Dosage and method:……...……..

Timing:……...…….

Special Precautions:……...……..

Side Effects:……...…….

Procedure to take in an emergency:……...……

CONTACT DETAILS

Name:…….. Daytime Tel No:……..

Relationship to Pupil:……

Address:……..

I understand that I must deliver and collect the medicine personally to the office staff, and accept that this is a service which the School is not obliged to undertake.

Date:……. Signature(s):……

Signature of member of office staff_____Date_____

Signature of Headteacher: _____ Date _____

NAME OF CHILD: ……………………………………..

Record of medicine administered to an individual child

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			

Date	/ /	/ /	/ /
Time Given			
Dose Given			
Name of member of staff			
Staff initials			