



Medication permission and record form

This form will only be accepted if received and signed by the parent/carer (not the child)
Please fill in a separate form for each of your child's medical or dietary needs

Pupil's Medical Information

Name of Pupil _____ Class: _____

What is the medication for (e.g. nut allergy, eczema etc): _____

Signs & symptoms (e.g. rash, swollen tongue etc): _____

Name of medication _____

Quantity received: _____ Date Received: _____

Expiry Date _____ Medication to be stored in fridge: Yes / No

Dose and method (how much and when taken): _____

Does the medication have any side effects? _____

Parent signature: _____ Print name _____

Date: _____

Date and quantity of medicine returned to parent

Staff signature _____ Parent signature _____

Print name _____ Print name _____

If administering a final dose of medication please return inform the school office.
Thank you



Record of Medicines given to a child in school

<u>Date</u>	_____	<u>Date</u>	_____
<u>Time given</u>	_____	<u>Time given</u>	_____
<u>Dose given</u>	_____	<u>Dose given</u>	_____
<u>Staff name</u>	_____	<u>Staff name</u>	_____
<u>Staff signature</u>	_____	<u>Staff signature</u>	_____
<u>Date</u>	_____	<u>Date</u>	_____
<u>Time given</u>	_____	<u>Time given</u>	_____
<u>Dose given</u>	_____	<u>Dose given</u>	_____
<u>Staff name</u>	_____	<u>Staff name</u>	_____
<u>Staff signature</u>	_____	<u>Staff signature</u>	_____
<u>Date</u>	_____	<u>Date</u>	_____
<u>Time given</u>	_____	<u>Time given</u>	_____
<u>Dose given</u>	_____	<u>Dose given</u>	_____
<u>Staff name</u>	_____	<u>Staff name</u>	_____
<u>Staff signature</u>	_____	<u>Staff signature</u>	_____
<u>Date</u>	_____	<u>Date</u>	_____
<u>Time given</u>	_____	<u>Time given</u>	_____
<u>Dose given</u>	_____	<u>Dose given</u>	_____
<u>Staff name</u>	_____	<u>Staff name</u>	_____
<u>Staff signature</u>	_____	<u>Staff signature</u>	_____