Administration of Medicines in School

Name of school					
Name of pupil		Class		DOB	
Medical condition		Length of course			
Prescribing Doctors Surgery		Quantity providing to school			
Medication name		Expiry date			
Dosage to be given		Frequency/Timings			
Time of last dose		Storage e.g. in fridge			

Parental Consent

☐ I confirm that I give permission for the designated members of staff to administer the medicine as above to my child during the time they are at school.

☐ I confirm that I take responsibility for ensuring all medication in school is in date and will replace medication before it expires.

☐ I confirm that any changes to the medication will be communicated to school.

☐ I confirm that in the event of a school trip, I consent to the medication be taken offsite for the designated members of staff to administer the medicine.

Parent/Guardian Name	
Parent/Guardian Signature	
Date	

For School Use

☐ I confirm that the medication received matches the information provided above.

Date	Time	Received/Returned	Name of Medicine	Quantity	Staff Signature	Parent/Guardian Signature

Administering Medicines Record

Name of pupil		Class	

Date	Time	Medicine administered	Dosage administered	Staff member 1 signature	Staff member 2 signature