SCHOOL MEDICINE RECORD

PART 1 To be completed by the parent/guardian. If more than one medicine is to be given, a **separate form** should be completed for **each**.

CHILD'S NAME: _____	DoB: _____	FORM: _____
Name of Medication: _____		
Reason: _____		
Dosage: _____		
How often/When to be given: _____		
Any other instructions: _____ _____		

DECLARATION I request that this medication be given, in accordance with the above information by the School Nurse or a responsible member of the school staff (who has received any necessary training). I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on the school premises.

I undertake to supply the school with medicines in their original properly labelled containers, which an adult will carry to school and hand over to the secretary at reception.

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent, and that the school staff may, therefore, need to arrange any medical aid considered necessary in an emergency, but I will be told any such action as soon as possible.

Signed: _____ (Parent/Guardian) Date: _____

Telephone number of parent or adult to contact: _____

Name of Doctor: _____ **Tel No:** _____

PART 2 To be completed by the School Nurse or other trained member of staff.

DATE													
DOSAGE													
TIME GIVEN													
SIGNATURE													