MEDICATION ADMINISTRATION FORM

The school **WILL NOT** give your child prescribed medicine unless you complete and sign this form. If more than one medication is to be given a **separate form must be completed for each one.**

PLEASR NOTE:

- **The school will only administer medicines that have been taken previously.**
- **A first dose of a new medicine WILL NOT BE GIVEN at school**
- **Medicines must be in the original container as dispensed by the pharmacy.**

Name of school	Rushwick CE Primary School
Name of child	
Date of birth	
Class	
Medical condition or illness	
Last date to be administered	

Medicine

Name of medicine	
Medication type (Tablet, Liquid etc)	
GP Name and Number	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – y/n	

PTO

Contact Details

Name	
Daytime telephone no.	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy.

I understand that I must deliver the medicine personally to the school office staff

I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s): _____ Date:_____

Medical Administration Record Form

Name of Child: _____

Date	Medication	Dosage	Time given	Name of administrator	Name of Witness