Dereham Neatherd High School

Medication At School Record Form

Medication At School Record Form

Name of Child:	
Name of Medicine:	
Date Start:	
Date Stop:	
Dosage & Method:	
Times to be administered:	
Special Storage Requirements: **(If YES Specify)**	**Yes / No (delete as appropriate)** **Fridge / Locked medication cabinet**
Child To Self-Administer:	**Yes / No (delete as appropriate)**
Teacher Supervision Required	**Details will be recorded of dose time & date**
Teacher To Administer Medication	**Yes / No (delete as appropriate)**
Is packaging original / used	**Yes / No**
Is information leaflet enclosed	**Yes / No**
Procedures to take in an Emergency	
CONTACT DETAILS **Name:** **Daytime Telephone No:** **Relationship to Pupil:** **Parent to deliver medication to School Reception**	....

Declaration

I hereby give permission for medicine to be given to my child in accordance with the details above. I understand that it is my child's responsibility to attend the First Aid Office. Pupils will not be collected.

....

Signature Name (block capitals) Date

Issue of Medication Record Form

Medication	Date	Time	Dose	How Taken	Expiry Date	Staff Initials	Date replacement medication requested