Medication Form

Date for review to be initiated by	**E Woodhouse**
Name of school/setting	**Escomb Primary School**
Name of child	
Date of birth	
Year Group	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
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	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	**Mrs Tague – School Office**

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Escomb Primary School staff administering medicine in accordance with the school policy. I will inform Escomb Primary School immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s)_____ Date _____

Record of Medication Administered

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			
Reactions			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			
Reactions			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			
Reactions			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			
Reactions			