

SCHOOL MEDICINE RECORD

This form is for parents or guardians to complete if they wish the school to administer medication to their children on their behalf.

Child's Name _____

Class/tutor Group _____

Name of medicine _____

Strength of medicine if appropriate _____

How much to give (i.e.dose) _____

When to be given _____

Any other instructions (include details for inhalers if any) _____

Phone No. of parent or adult contact _____

Tick appropriate box

Medicine to be left at school

Medicine to be taken home each day
e.g. antibiotics

In consideration for the School Nurse or the school staff agreeing to give medication to my/our above named child during school hours, I/we agree to indemnify the School Nurse, school staff against all claims, costs actions and demands whatsoever resulting from the administration of the medicine unless such claims, costs, actions or demands result out of the negligence of the School Nurse or school staff.

Parent/Carer's signature. _____

If more than one medicine is to be given a separate form should be completed for each.

DATE														
TIME GIVEN														
SIGN														

Date medicine returned to parent on completion of course of medicine. _____