



MEDICATION RECORD

Child's Name _____

Class/tutor group _____

Condition medicine is for
(i.e. Asthma, nut allergy) _____

Name of medicine _____

Strength of medicine _____

How much to give
(1 puff wait for 10 then another puff) _____

When to be given _____

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

Medicine Expiry Date _____

Phone No. of parent or adult contact _____

Tick appropriate box

Medicine to be left at school

Medicine to be taken home each day

1. In consideration for the Headteacher or the school's staff agreeing to give medication to my/our above named child during school hours, I /we agreed to indemnify the Headteacher, the school's staff and the Local Education Authority 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 Headteacher, the school's staff or the Local Education Authority.

Parent's Signature: _____ Print Name: _____

Date of Signature: _____

For Internal Use Only

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

Great Barford Church of England Primary Academy



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Date											
Time Given											
Sign											
Witness											

Date											
Time Given											
Sign											
Witness											

** When medication is given to a child, this form must be signed by the member of staff administering the medication and then witnessed by another member of staff. Medication required*

