St. John's Church of England Academy

Medication Form

PLEASE USE CAPITAL LETTERS

Pupil's name……. D.O.B: ……

Class……..

Address……..…

……..…

Contact telephone number……...

Name of Doctor who prescribed the medication ……

Surgery address……

Is this a 'dual' prescription to be left in school? Yes ☐ No ☐

What is the medication for? .....

Is this the first time your child has taken this medication? Yes ☐ No ☐

Date	Person who brought medication	Name of medication	Amount in bottle or packet	Amount to be taken	When medication to be taken

I am aware that my responsibilities as parent/carer are:

- To keep the school informed of any changes in medication.
- To ensure that medication is in date and provided for the school as required.
- To keep my contact details up to date.

Parent/Carer's signature……..

Date …….

Register of Medication Administered

Record the date if medication was not returned

Date	Medication	Amount given	Amount left	Time	Administered by

Record the date if medication was not returned

Date	Medication	Amount given	Amount left	Time	Administered by