KINGSWESTON SCHOOL

Record of Medication to be <u>Administered in School</u>

Pupil Details

Surname	**Forename**
Date of Birth	**Class**
Address	**Parent/Carer** Emergency phone Numbers **Home:** **Mobile:**

Child's Photo

Medication to be given in School

Medication

Name of Medication (as written on container):	Type of medication e.g. tablet/liquid/inhaler:
Exact Dosage:	Method of administration:
Preferred time for Dosage:	
Special Instructions e.g. With food/ after food etc	

Medication

Name of Medication (as written on container):	Type of medication e.g. tablet/liquid/inhaler:
Exact Dosage:	Method of administration:
Preferred time for Dosage:	
Special Instructions e.g. With food/after food etc	

Details of Parent/Carer requesting medication to be given in school

Name:	Relationship to pupil:
Address:	Daytime telephone number(s):

You will be contacted if your child shows any adverse reaction to medication given in school.
If your child vomits or spits out the medication given, the dose will not be repeated.
I give my consent for the nominated persons to administer the above medication.

Signature: _____ Date: _____