MILL HILL PRIMARY SCHOOL

PUPIL RECORD OF MEDICATION

Surname: _____ **Forename:** _____ **D.O.B:** _____ **Class:** _____

Medication: _____

Dosage: _____ **Frequency:** _____

I give consent for my child to be given their prescribed medication detailed above. I accept full responsibility for any consequences the taking of that medicine may bring.

Signature of Parent/Carer: _____ **Date:** _____

Relationship to child: _____

Any reactions/remarks: _____

_____

Medication returned to parent/carer: ☐ Date: _____ **OR** Destroyed: ☐ Date: _____

Date	Time	Dose given	Person Administering	
			Name	Signature